

Making a Diversity Difference: Stories of Leadership in Creating a More Inclusive

Nursing Profession

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by

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## **ABSTRACT**

Societies in the developed world are becoming increasingly diverse as they experience growth in the number and size of minority groups, including visible minorities, immigrants, and, in some countries, Indigenous peoples. Society's institutions, including the health care system and its professional groups, are increasingly challenged to enhance their understanding of and respect for such societal diversity in providing services, and to work to reflect this diversity in the makeup of their membership. While many of the health care professions, including nursing, have acknowledged the importance of inclusion of individuals from diverse groups, their successes in meeting targeted increases have been limited.

The purpose of this research was to elicit stories of nursing leadership that successfully promoted diversity and enhanced inclusiveness within the profession. The research problem was stated as follows: What were the experiences and stories of nurse leaders who successfully provided leadership to increase diversity and inclusion within the profession? The study used modified narrative inquiry research methods. The research was built on a conceptual framework consisting of three major concepts: diversity, critical leadership, and professional closure.

The study focused on the stories of five Canadian nurse leaders who described and explained through their stories their leadership characteristics and challenges. Their stories of promoting diversity and inclusion were explored from a critical perspective, using literature found primarily in the fields of nursing and education to guide the exploration.

These leaders' stories revealed their understanding that the nursing profession currently expected its members to represent the norm-- white middle class females. The stories showed that the participating nurse leaders generally had views of diversity that were broader than culture, ethnicity and race, the views that were most commonly addressed in the mainstream nursing literature. Their broad views of diversity included difference based on gender, sexual orientation, and ability. These views often arose from personal experiences of difference related to ethnicity, language, country of origin,

gender, presence of an accent, or family circumstances. The leaders interviewed indicated that they saw a lack of tolerance for difference within the profession, but not simply in relation to cultural or physical difference. They described a lack of acceptance within the profession of different ways of thinking and being—referred to in the study as *diversity of thought*. They reported that the profession expected and reinforced conformist thinking and tended to support the status quo.

The study findings contributed to an expanded understanding of the conceptual approach of *critical leadership* as a process to support diversity and promote inclusion in the profession. A conceptual framework for critical leadership, based on the work of Foster (1986; 1989) and Ryan (2006a; 2006b) was enhanced and expanded as a result of the study findings. Critical leadership involved critique, transformation, education, ethics, and inclusion.

The study findings supported the view that the profession of nursing, perhaps inadvertently, limited access to the profession by marginalized groups. This process was called professional closure, and occurred as a result of increasing entrance requirements, inconsistent language requirements, and segmenting minority groups in lower paid practical nurse and front line positions, with little opportunity for advancement.

These findings about diversity and leadership, and about leadership for diversity, challenged the nursing profession to look beyond its day-to-day busyness, and to move beyond its current locked-down, controlled, risk-averse practices. The study findings challenged the profession to embrace the possibilities of increasing its diversity and inclusiveness, with the ultimate goal of building a better, stronger, more just profession and a better, stronger, more just society.

The study has significant implications for theory, practice, research and policy in the profession. From a theoretical perspective, the study pointed to the need for the nursing profession to contemplate its social obligations with respect to promoting social justice in society. The study findings suggest that the profession might engage in national level policy discussions committed to increasing the diversity of the profession in order to reflect the community it serves. This study suggests the need for additional qualitative and quantitative studies on critical leadership to further develop the conceptualizations

that evolved in this study. Policy discussions are implicated to address approaches to difference, inclusion, culture, cultural competence, cultural safety, affirmative action and inclusive policy in nursing, nursing education and health care institutions.

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## **DEDICATION**

This work is dedicated to the memory of my parents, Hugh and Beth Berry, who taught me the importance of education. Their love, support and belief in me gave me the confidence to pursue my dreams. I only hope that I can be inspired by their example to support my own children in the pursuit of their dreams, and that I can create such opportunities for the nursing students I teach.



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## **CHAPTER 1: THE NATURE OF THE PROBLEM**

### **Introduction**

Today's developed societies are becoming increasingly diversified. They are experiencing growth in the number and size of minority groups, including visible minorities, immigrants, and, in some countries, Indigenous peoples. Society's institutions, including the health care system and its professionals, are charged with the responsibility of understanding and respecting this diversity in providing services, and reflecting it in the makeup of their membership. While many of the health care professions have acknowledged the importance of inclusion of individuals from diverse groups, their successes in meeting targeted increases have been limited.

In developing this study, I have investigated the experience of increasing participation of visible minorities, immigrants and Aboriginal peoples in a specific health profession, nursing. I did this through the gathering and analyzing the stories of five Canadian nursing leaders who were acknowledged by their formal nursing leader peers as having successfully provided leadership to increase the participation of these groups in the profession. This study focused on the stories of these selected leaders, and their leadership for inclusion, in an effort to describe and explain their leadership characteristics and challenges. The concepts and practices of diversity and inclusion were explored from a critical perspective. Barriers that exist in relation to power relationships within society and its institutions, including the professions, were addressed. The purpose of this research was to elicit stories of successful leadership to promote diversity and enhance inclusiveness in nursing.

### ***Background to the Problem: Why Study Diversity in Nursing?***

This study was rooted in the knowledge that the diversity of Canada's population is increasing. Diversity is increasing because of the manner in which Canada's population is growing. Canada's population growth is currently dependent on two factors: continued immigration and continuing growth of the Aboriginal population. With respect to immigration, Canada remains one of the three major immigration destination countries in the world, alongside the United States and Australia.

Immigrants to Canada are largely from visible minority groups. (The concept of visible minority is a construct of Statistics Canada, the statistical arm of the Canadian government. It is used to describe non-white, non-Aboriginal populations (Statistics Canada, 2001). The term is used in this study with caution. The issues surrounding this term are discussed further in the section of this chapter that identified the limitations of the study.) Three quarters of the immigrants who arrived in Canada between 2001 and 2006 belonged to visible minority groups (Statistics Canada, 2008). Thus immigration has contributed, and will continue to contribute significantly to the increasing diversity of Canadian society.

In addition to the immigrant and visible minority population, the Aboriginal population in Canada continues to grow at a rate greater than that of the total Canadian population. Between 1996 and 2006, the Canadian Aboriginal population grew by 45%, almost six times faster than the non Aboriginal population which grew at a rate of 8% (Statistics Canada, 2008). In 2006, in Saskatchewan, the Canadian province where this study originated, Aboriginal people made up 14.9% of the population (Statistics Canada, 2008).

Increasing diversity within society impacts society's institutions. Organizations in fields such as health care and education have been challenged to provide services to meet the needs of populations with widely varying needs. Government and health care organizations in the English-speaking world have identified meeting the needs of an increasingly diverse society as a major challenge facing the health care system. The U. S. Symposium on Diversity in Health Professions, 2001 summarized the problem in this way:

Many minority groups... are poorly represented in the health professions relative to their proportions in the overall U.S. population. These groups also tend to be less healthy than the U.S. majority, experience greater barriers to accessing health care, and often receive a lower quality and intensity of health care.... Further, the proportion of these groups within the U.S. population is growing rapidly, increasing the need to respond to their public health and health care needs. This disparity presents a significant challenge to the health professions and to educators, as they must garner all available resources to meet future health care demands. (Nickens & Smedley, 2001, p.2)

Both the Sullivan Commission report *Missing Persons: Minorities in the Health Professions* (2004) and the Institute of Medicine document, *In the Nation's Compelling Interest: Ensuring Diversity in the Health-care Workforce* (2004), acknowledged that minority groups in the United States experienced significant health problems that were not being addressed by the current system, and proposed increased diversity in the health professions as a mechanism for addressing these concerns.

The aforementioned reports address issues in the American health care system. While the American and Canadian health care systems are vastly different in their underlying political philosophies, funding mechanisms, governance, and approaches to accessibility, similar problems regarding the health of minorities do in fact exist in the Canadian context. In Canada, the *Royal Commission on Aboriginal People* (Indian and Northern Affairs Canada [INAC], 1996) determined that the diverse needs of Aboriginal people were not being met by Canadian institutions, including the education and health care systems. The Commission identified the need for more Aboriginal health professionals as one means to meet the health needs of Aboriginal peoples. The Royal Commission indicated that Canada needed 10,000 Aboriginal Health professionals---a ten-fold increase (INAC, 1996). Yet, by 2004, only 150 of the 53,000 physicians in Canada were of Aboriginal ancestry (Ehman, 2004). The limitations of this increase are even more severe when one considers that the Aboriginal population in Canada is growing at a rate considerably faster than the growth of the population in general. The Aboriginal population grew by 20.1% between 2001 and 2006 (Human Resources and Skills Development Canada [HRSDC], 2010) as compared with the general population increase of 5.4% (Natural Resources Canada, 2009). One might assume that the numbers of required Aboriginal health professionals identified in the 1996 Royal Commission have increased proportionally with the increase in the Aboriginal population.

Many health professional groups have embraced the proposals for increasing the number of minority health professionals. The Association of American Medical Colleges launched its diversity program, entitled *Project 3000 by 2000* in 1991 (Terrell, 2006). For a variety of reasons---legal, legislative and political--- this goal was not met. By the year 2000, there were 1,700 underrepresented minority students in U.S. medical schools, an

increase of less than 200 in a decade (Terrell, 2006). The journal of the Association of American Medical Colleges dedicated an entire issue supplement to the topic of promoting minority access to medical education in July, 2006. Clearly the need for increased diversity in the health professions continues to be on the international agenda. This recognition of the importance of increasing diversity in the health professions supports the aim of this study in its attempt to understand leadership aimed at increasing diversity and inclusion in the profession.

### *The Case for Diversity in Nursing*

The need for diversity in the health care professions holds true also for the profession of nursing. The U.S. based 2001 Symposium on Diversity in Health Professions indicated that nursing was in a unique position to increase participation of underrepresented minorities (URMs) for two reasons: it was the only health profession that did not require a baccalaureate degree for initial licensure to practice, and it had several different educational entrance points into the profession, in the form of diploma, associate degree, and baccalaureate degree credentials (Grumbach, Coffman, Rosenoff, & Munoz, 2001). Grumbach et al. indicated that nursing in 2001 had the highest proportion of URM enrollees of any health profession, other than public health. They reported a steady increase in URM enrollment in baccalaureate nursing programs between 1991 and 1999. URM enrollment increased in actual numbers at a time, when non URM enrollment was decreasing, resulting in an overall increase in the percentage of URMs from 12.2% in 1991 to 16.0% in 1999 (Grumbach et al., 2001).

Canadian statistics on ethnic and racial makeup of the health care professions are not collected in the same manner as the United States. As a result, we do not have a clear statistical picture of minority representation in the Canadian health professions. There is, however, general agreement that the makeup of nursing is not representative of the Canadian public (Canadian Nurses Association [CNA], 2008a; International Council of Nurses [ICN], 2004a; ; ICN, 2004b; Villeneuve & MacDonald, 2006). Nurses are predominantly white, middle class, and female (Chua & Clegg, 1990; Huston, 2006; Newell-Withrow & Slusher, 2001; Page & Thomas, 1994).



The Canadian Nurses Association supported the increased participation of Aboriginal people and visible minorities in the nursing workforce, calling for 20% of nursing leaders to come from Aboriginal and visible minority populations by 2020 (CNA 2008a; Villeneuve & MacDonald, 2006).

***Diversity: Fairness, Function, & Parity of Participation***

Arguments in the literature supporting the promotion of diversity in the health professions generally addressed two issues: *fairness* and *function* (Nickens & Smedley, 2001). The *fairness* argument maintained that many racial and ethnic minorities have traditionally been excluded from economic and professional opportunities. Mechanisms are necessary to recruit and retain health professionals as a mechanism of redress for such exclusions. The *functional* argument maintained that the needs of minority groups can best be met by members of their own culture, ethnic or racial group.

The functional assumption that the needs of minority groups can best be met by their own groups is an argument commonly expressed and has an intuitive sensibility. However, there has been little research done to actually support this assumption. In the absence of evidence, such assumptions can be viewed as essentialist, ascribing characteristics and abilities to these groups, simply on the basis of their minority group status.

Rather than seeing difference from the either/or perspective of fairness or function, Kirkham and Anderson (2002), suggested that the central notion common to both perspectives, is *parity of participation*, meaning that "...justice requires social arrangements that permit all (adult) members of society to interact with one another as peers" (p. 327). Participation becomes the objective of justice, without ascribing any untested assumptions regarding the outcome of participation on minority groups.

While addressing both fairness and function in increasing the participation of minority groups in the profession, this study focused primarily on the parity of participation aspect—that is, increasing participation of visible minorities, immigrants and Aboriginal peoples in nursing as both a goal and a process of inclusion and social justice. The concept of parity of participation, and a discussion of barriers to inclusion in

the nursing profession were outlined in detail in the review of the literature in Chapter Two.

### *Nursing and Professional Closure*

Nursing in Canada is a self regulated profession. Self regulated professions are given the legislated authority to determine their own educational and practice standards, discipline their own members, and regulate their own practice (CNA, 2007). Professions such as nursing enjoy positions of privilege and respect in society based on their social contract with the public they serve (Sullivan & Benner, 2005). Within this social contract, the profession assumes the social responsibility for creating, maintaining and policing standards of care within its membership. In exchange, the state delegates to the profession the authority to regulate its own affairs, including determining who enters the profession, how they are educated and how they perform their duties (Sullivan & Benner, 2005). Inherent in this social contract is the expectation that professions such as nursing will respond to the needs of society.

Despite this social contract, some writers believed that professions misuse the privilege they are given by limiting access to the profession, in an attempt to maintain and increase professional power and prestige (Baskerville-Morley, 2006; Walker & Shackelton, 1998). Creating barriers and limiting access to the profession for the purpose of maintaining professional status is called *professional closure*. The concept of professional closure originated in Weber's notion that "...social groups seek to regulate market conditions in their favor, despite competition from others, by restricting access to opportunities...Closure may also yield social rewards" (Baskerville-Morley, 2006, p. 296). Professional closure was directed at the formation of a professional class.

Weberian closure theory differentiated between eligible insiders and those classified as outsiders based on attributes such as race, education, occupation, gender or wealth (Walker & Shackelton, 1998). Baskerville-Morley claimed that closure might not be intentional, but might occur inadvertently or "by proxy," as a result of requirements imposed, such as requirements around residency, language or admission. The review of the literature in Chapter Two with respect to professional closure in nursing explored

some of the systemic barriers experienced by nurses from underrepresented groups, such as language requirements, academic prerequisites, and practice requirements.

### ***Critical Leadership for Inclusion in Nursing***

I chose to study diversity in nursing because I was and continue to be acutely interested in issues of social justice, and the roles that professions play in challenging or supporting injustice. As a nurse educator in Saskatchewan, Canada for over 30 years, I was well aware of the barriers faced by, and the lived experiences of, the few minority students who enter nursing education during this time. As a middle- and senior- level nursing education administrator for 15 of those years, I experienced the difficulties in attempting to develop and implement policies and programs at educational institution and government levels to support the success of minority students in nursing education. I saw the importance of skilled leadership in accomplishing goals around diversity, and experienced the frustration when such leadership was lacking. I could easily have chosen to focus this study on the barriers, challenges, and frustrations of addressing diversity in nursing.

However, I am, by nature, a positive person. I was interested in change and positive growth, and in focusing on what works in our society. To simply focus on the “problem” of diversity within the profession, and the “barriers” and “challenges” experienced by underrepresented groups, including the mechanisms of closure either intentionally or inadvertently employed by the profession, served only to pathologize the issue. While recognizing the importance of awareness of the issues, I was not content to dwell on the negative. I wanted to study *success*. This, coupled with my own leadership experiences, led me to focus on *successful leadership* for diversity and inclusion in nursing.

This study focused on leadership in nursing directed at supporting and empowering underrepresented minorities in nursing. It did so by focusing on leaders who accepted the challenge of increasing diversity and equity in nursing for the purposes of enhancing fairness, addressing power imbalances, and challenging the status quo. The study was informed by my commitment to social justice and critical transformation. It

focused on *critical* approaches to leadership. Critical approaches to leadership were summed up by Foster (1989):

Leadership is at its heart a critical practice, one that comments on present and former constructions of reality, that holds up certain ideals for comparison, and that attempts at the enablement of the vision based on an interpretation of the past. In being critical, then, leadership is oriented not just toward the development of more perfect organizational structures, but toward a reconceptualization of life practices where common ideals of freedom and democracy stand important. (p.52)

In summary, the study focused on diversity in nursing, barriers to participation in the profession that act to produce professional closure, and the critical leadership necessary to address these barriers and increase the success of those in Aboriginal, visible minority and immigrant populations who want to participate in nursing as a profession.

### **Purpose of Research**

The purpose of this research was to help create an understanding of leadership and the leadership roles of champions of diversity within the profession as they aimed to increase diversity in nursing. This understanding flowed from the stories of nurse leaders who advocated for the inclusion of Aboriginal people, visible minorities and immigrants within the profession. This study was intended to explore and interpret the concepts of diversity and inclusion through the stories of these selected nursing leaders in order to understand, through their stories, the role of critical leadership in achieving a more diverse nursing profession, the composition of which is reflective of the population it served.

### **Statement of the Problem**

The research problem was as follows: What are the experiences and stories of nurse leaders who have increased diversity and inclusion within the profession through their leadership?

### **Research Questions**

1. How have these nurse leaders come to their current conceptions of leadership, and what are these conceptions?
2. How have these nurse leaders come to their current conceptions of diversity and inclusion, and what are these conceptions?

3. How might the range and variety of experiences and stories of nurse leaders be described with respect to leadership for diversity and inclusion within the profession and the relevant systems?

### **Significance of the Study**

This research was intended to increase the understanding of the concepts of diversity, difference and inclusion in relation to the nursing profession. It was aimed at revealing the importance of increasing diversity and promoting inclusion within the nursing profession, and inspiring other nursing leaders to support and promote diversity and inclusion. It was intended to assist other nursing leaders to understand their profession and related institutions with respect to diversity and inclusion, and to share with them stories of others who have succeeded in promoting diversity and inclusion within these organizations. The aim of this research was to story the processes of professional closure within the nursing profession, the barriers to participation by underrepresented minorities in the profession and the health care system, and the leadership necessary to make possible and support this participation. It was intended that this qualitative study would inspire future studies on leadership for inclusion in nursing and other health professions, creating a foundation on which other studies could build.

This study was intended to make an original contribution to the scholarship in the nursing profession around the concepts of diversity, difference and inclusion, and to provide rich, descriptive, inspirational stories about these concepts. It also served to introduce the literature and concepts of critical leadership and leadership for social justice, found in the education literature, into the nursing literature. (Critical leadership, for the purposes of this study, involved approaches to leadership that addressed critique, transformation, education, ethics and inclusion. Critical leadership is defined and discussed in Chapter Two). The study was significant in its addition to the leadership literature found in education of an enhanced understanding of leadership in other professions, such as nursing. In bridging the professions of nursing and education, this study was intended to offer perspectives on inclusion and leadership to the scholarship of other health professions, and professions in general.

The study was significant because there is little research addressing leadership to promote diversity in nursing. While there are many studies and articles addressing the barriers experienced by minority nurses and nursing students, and there are many calls for increased inclusion of underrepresented minorities in nursing, there was limited research found on leadership to promote diversity, and even less research on the issue from a critical leadership perspective. Periodical searches conducted on Cumulative Index to Nursing and Allied Health Literature (CINAHL) on January 14, 2009, using the word combinations diversity/ leadership/ critical theory, diversity/leadership/ social justice and diversity/leadership/nursing revealed no resources. ProQuest searches for dissertations in the field using the same word combinations revealed only one dissertation, dealing with leadership approaches of female nurse and non nurse CEOs (McPeak, 2004).

### **Assumptions Associated with the Study**

For the purposes of this study, assumptions were considered the “self evident truths”, accepted but unproven, on which the study is built (Calabrese, 2006). The underlying assumptions were related to the theoretical and conceptual frameworks of the study (1–2), as well as to methods and methodology (3-7). These assumptions included that:

1. Leaders in nursing who are interested in increasing nursing diversity do so for reasons beyond compliance with organizational, institutional or professional policy. These leaders are driven by internal commitment to increased diversity, rather than external requirements.
2. Exclusion of diverse underrepresented minorities from professional participation is related to power and control within society, professions and the health care system.
3. A narrative approach to the topic of leadership in nursing provides rich descriptions of leadership that might serve as examples for further exploration of difference and leadership in the nursing profession from a critical perspective.

4. The themes of leadership, diversity and professional closure which arose during the review of the literature would resonate with the stories shared by nursing leaders.
5. Participants would share their stories authentically, honestly and perceptively.
6. Research methods chosen and developed by the researcher would enhance the understanding of the research problem.
7. The study would lead to increased understanding, provide meaning, and inspire critical and inclusive practices within the profession.

### **Limitations of the Study**

Research study limitations include areas in the design that could potentially restrict the scope of the study (Calabrese, 2006). It was important to identify factors in the design of the study that might have limited or restricted the findings. Limitations of this study were as follows:

1. This study was limited by the current frameworks for collecting statistics on immigrants, Aboriginals, and visible minorities. In describing the background of the study, I was limited in the way in which jurisdictions define and categorize population groups. For example, Canada used the term “visible minorities” to categorize non-white, non-Aboriginal populations. Canada has been criticized by the United Nations Committee for the Elimination of Race Discrimination (CERD) for its use of the term “visible minorities” as it connotes a “...sense of inferiority and constructs the situation of ‘visible minorities’ to be permanently on the margins or the outside—‘the other’ ” (Canadian Race Relations Foundation [CRRF], 2007, p. 2). CRRF also criticized the homogenization of different groups by categorizing them under this umbrella term.
2. A crucial limitation of this study occurred as a result of the withdrawal from the study of a sixth participant late in the study process. This participant, a nurse leader and member of a large and important minority

group, and the only participant who described herself as coming from a background of poverty, participated willingly in the study interviews, but withdrew during the final stages of the study, as the last minute touches were being made to her narrative, its analysis and the discussion of the findings and implications of the study. As a result of her withdrawal, the powerful voice of a member of a significant minority group was lost to the study. The limitations and methodological considerations that arose as a result of this participant's withdrawal from the study are chronicled in more detail in Chapter Three.

3. This study was potentially limited by the choice of telephone interviewing techniques instead of face-to-face interviews. A more detailed discussion of the implications of using telephone interviews is contained in Chapter Three.

### **Delimitations of the Study**

Delimitations of a research study are the self imposed limitations used to narrow and contain the boundaries of the study (Calabrese, 2006). The process of delimitation identified aspects that the researcher chose not to address in an attempt to impose manageable and conceptually congruent parameters on the study. The delimitations of this study included the following:

1. The study was delimited to five participants, three of whom were identified to me as leaders for diversity and inclusion in the profession by three formal national nursing leaders in Canada (These formal leaders included the president of the Canadian Nurses Association, the president of the Canadian Association of Schools of Nursing, and the executive director of the Saskatchewan Registered Nurses Association). The initial study participants were identified and acknowledged by the formal leaders of national nursing organizations as individuals known for their successes in this area. Two additional participants were identified during interviews with the initial study participants. The initial study participants then named two additional colleagues as study participants. These colleagues



were known to the initial study participants to have had comparable success in increasing diversity in the profession.

4. The study was delimited to the involvement of leaders who have addressed inclusion of Aboriginals, visible minorities and immigrants. While leaders who are committed to inclusion of members of these groups may also address inclusion of other groups such as lesbians, gay men and disabled individuals, these groups were not the specific focus of the leaders in this study.
5. The study did not address gender issues, and the issue of increasing the participation of men in nursing, even though in 2005, only 5.5% of Canadian nurses were male (Canadian Institute for Health Information [CIHI], 2005). While men were clearly an underrepresented minority within nursing, there was evidence in the literature that they are disproportionately over-represented in the leadership and administrative ranks of the profession, and that they earn more than female nurses. As such, they do not suffer the same economic and power disadvantages that other underrepresented groups experience within the profession (Evans, 1997; Evans, 2004; ICN, 2004a; ICN, 2004b; O'Connor, 2003). Therefore, while I was interested in the experience of difference of males in the profession, leaders recruited for this study were not recruited for their specific interest in and action around the recruitment of men into the profession.

### **Definitions**

In this section, I defined some of the frequently used terms in the study.

- **Aboriginal:** The term Aboriginal referred to populations that inhabiting or existing in a land from the earliest times or from before the arrival of colonists. As cited in the Canadian Constitution, the term “Aboriginal people of Canada” included the Indian, Inuit and Métis peoples of Canada (Department of Justice, 1982). The term Aboriginal is used primarily in Canada, with a variation

- (aborigine) used in Australia. The term Indigenous is synonymous and used more widely internationally.
- Immigrant: The term immigrant referred to an individual who has come to settle in a country different from that where he or she was born. For the purpose of this study no differentiation was made on the basis of the reason for immigration (political refugee status versus voluntary immigration).
  - Story: An account or description of remembered events, which, by its telling, endowed the experience with meaning (Bleakley, 2005). (Note: Differences in the use of the terms narrative, story, and experience are addressed in Chapter Three).
  - Nurse: For the purposes of this study, this term referred to a registered nurse. A registered nurse is an individual who has completed a four year baccalaureate degree in nursing, or a two year diploma or associate degree in nursing, and who has applied for and been granted registration with the professional nurse registering or licensing body. The term is not used in this study to describe licensed practical nurses, registered practical nurses, licensed vocational nurses, registered psychiatric nurses, or unregulated personal care providers.
  - Visible minority: This study adopted (with reservations noted in the section on *Limitations of the Study*) the Statistics Canada definition of visible minority: “persons, other than Aboriginal persons, who are non-Caucasian in race or non-white in colour” (2001, p. 3, 11).

### **Organization of the Dissertation**

The dissertation was divided into five chapters. Chapter One introduced the problem, and described the background to the issue. It identified some of the issues surrounding diversity in nursing, and introduced the concept of professional closure. It introduced the concept of critical leadership as the principle approach used to look at leadership for diversity in the study. Three concepts—diversity, professional closure, and critical leadership—formed the conceptual framework of the literature review and the study. These concepts emerged as I did my “homework” to understand the background of the study. They were the prominent themes in the literature that resonated with me as I

delved into the issues surrounding diversity, inclusion and leadership from a critical perspective. These concepts served as a starting place for my explorations.

Chapter Two reviewed the literature related to the three main concepts of the study. In this chapter I reviewed the literature related to exclusion and diversity, including a look at diversity within nursing. I explored the theoretical background surrounding professional closure in its historical and modern contexts. Chapter Two concluded with an exploration of the literature surrounding critical leadership, addressing Foster's concept of critical leadership, and related critical approaches: transformational leadership, transformative leadership, inclusive leadership and leadership for social justice. I briefly discussed the literature around related character-based approaches to leadership, including leadership as vocation, authentic leadership and servant leadership. The chapter concluded with a discussion of social justice and leadership for social change in the nursing profession.

Chapter Three addressed the research methodology and design. This study used adapted narrative inquiry approaches and techniques to explore the research questions. Research methods, purposive sampling techniques, data collection and analysis, plus ethical, ontological, and epistemological considerations were outlined in this chapter.

Chapter Four contained the findings of the study, in the form of constructed narratives of the five participants of the study outlining their experiences in increasing diversity and inclusion in the nursing profession. Each participant narrative was included, followed by an analysis of the narrative in relation to the overarching themes of the study. Following the recounting and analyzing of each of the individual stories, a meta-analysis was included, analyzing themes common to and divergent among all of the narratives.

In Chapter Five the research findings were discussed in relation to the research questions. The findings were related to those in the literature, and also to those in my own experience. The implications of this study on practice, policy development, research and theoretical advancement were addressed. The study concluded with my personal reflections on the research processes and their impact on me as a professional and a leader.

### **Summary and Conclusions**

The increasing diversity of western society has placed requirements on society's institutions, including the health care system, and its health professions. Increasing the number of health care professionals from minority groups has been proposed as a responsive mechanism directed at better meeting the health needs of minority groups. However, to date, there has been limited success in accomplishing this. This study focused on the stories of nurse leaders who have succeeded in increasing minority participation in the profession, as evidenced by their acknowledged success and their recognition by nurses holding formal national leadership positions in nursing organizations. The following chapter provides more background on the issue of minority participation, and explores the theoretical concepts of diversity, professional closure, critical leadership, and their interrelationships.

## **CHAPTER TWO: REVIEW OF RELATED LITERATURE**

### **Introduction**

This chapter reviews the literature which informed this study. The literature in three major areas is addressed: diversity, professional closure and critical leadership. In order to understand the background and issues with respect to diversity and inclusion in nursing, the chapter includes a review of the demographics of the increasingly diverse makeup of modern Western societies, and the health professions, including nursing. Theoretical frameworks and perspectives on difference are reviewed, including deficit-based concepts of diversity and multiculturalism, and asset-based approaches to difference, including communities of difference. This chapter explores the concept of professional closure and exclusion in relation to the health professions and nursing. The chapter concludes with a review of the leadership literature, including the concept of critical leadership and Foster's conceptualization of critical leadership. The chapter explores Foster's approach, and compares this approach with several other related and supporting approaches to leadership, including transformational leadership, transformative leadership, inclusive leadership, leadership for social justice, leadership as vocation, authentic leadership and servant leadership. A review of the limited nursing literature available on critical leadership, leadership for inclusion, and leadership for social justice concludes the chapter.

I chose to review the literature in these areas because it resonated with and informed my own experiences as a leader promoting diversity within nursing. I believed that this literature is relevant to understanding the experiences and stories of the leaders in the study. As there was virtually no literature available in the nursing field on critical leadership, leadership for social justice, and leadership for inclusion, the choice of this literature initially represented my "best guess" as to what would inform this study. The feedback from the participants validated the choices made in reviewing the literature. The one area of leadership added as a result of the interviews was servant leadership, an area not included in the original proposal and arising from interviews with one participant.

I found that much of what was written in the literature with respect to diversity, leadership and exclusion of underrepresented groups in mainstream society was based in the education literature. This appeared to be due to the significance of education in

creating opportunities, or conversely, failing to include and prepare these groups, for full participation in society. As a result, much of the literature discussed in this literature review comes from the fields of education and educational administration. The nursing literature in the areas of diversity, professional closure and leadership was also explored.

### **Conceptual Framework of the Study**

Calabrese (2006) described the conceptual framework of a study as “providing an explanation of the relationship among the factors, constructs, or key variables in the inquiry” (p. 24). The major concepts of this study included diversity, professional closure and critical leadership. These concepts formed the basis of the conceptual framework. They were viewed in relation to nursing as a profession. The relationship between the profession and the major concepts of the study—diversity, professional closure, and critical leadership—is diagrammatically represented in Figure 2.1.

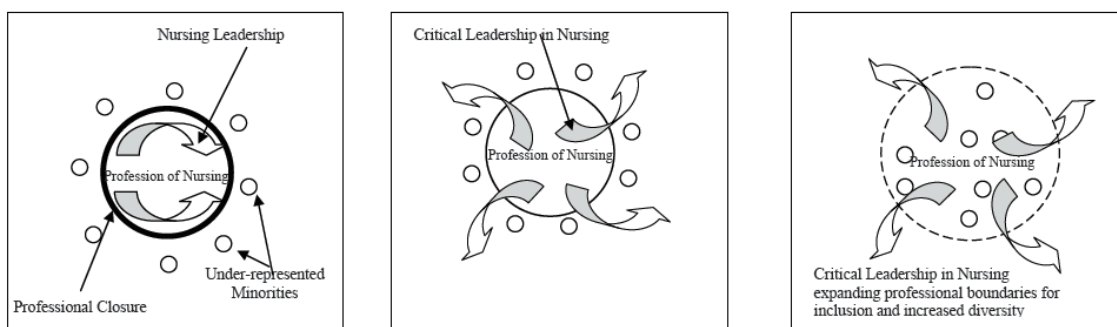
The trend toward an increasingly diverse population challenges the nursing profession. In response to its contract with society, the profession is compelled to address this trend. The profession does so through provision of culturally appropriate care to minority populations, but also through increasing membership of these groups in the profession itself. Minority groups are not currently represented in the nursing profession in representative numbers, as depicted by their appearance on the periphery of the profession in Figure 2-1. Currently the groups who formed the focus of the study, namely immigrants, visible minorities and Aboriginal people are not proportionally represented in the profession, which is largely white, female and middle class.

Increasing the membership of minorities in the nursing profession is a response to issues of function and fairness. From a functional standpoint, it is postulated that increasing the representation of minorities in health professions will enhance the relationship of minorities with the health care system, and, ultimately, improve the health of minorities. From a fairness perspective, increasing minority representation in the profession is directed at righting past wrongs, by facilitating inclusion as a mechanism to achieve social justice. Ultimately, the issue is one of parity of participation, where all members of society have equal right to participate in society’s institutions and practices.

Professional closure exists to maximize the status and privilege of the profession, and advance its influence within the system. Profession closure serves as a barrier to participation for minority groups. While professional closure serves to limit access to the profession for minority groups, the barriers to inclusion are not necessarily intentional, but may be inadvertent byproducts of attempts to increase the professionalization of nursing. This closure is demonstrated in Figure 2-1 by the heavy line encircling the profession, acting as an obstruction to minority participation.

Critical leadership acts on the profession from within, in an attempt to build links between the profession and the diverse community, and ultimately society at large. Through its emphasis on critique, transformation, education, ethics, and inclusion, critical leadership aims to penetrate the barriers created by professional closure, to look beyond the margins of the profession, to expand the borders of the profession, and to increase the permeability of the professional borders to promote representation of minorities within the profession, in an attempt to address social injustice within and outside the profession. Critical leadership moves the profession from an internal focus, as illustrated in the first diagram, to a focus beyond the profession, linking with society and responding to its needs. Critical leadership serves to break down the barriers posed by professional closure and to promote inclusion and increased diversity within the profession, as depicted in the third diagram.

The concepts of professional closure, diversity and critical leadership are explored and developed through this review of the literature.



**Figure 2.1 Conceptual Framework: Relationship between Diversity, Professional Closure and Critical Leadership**

### **Approach to the Literature Review**

Review of the literature was carried out using the resources of the University of Saskatchewan library system, including the Education, Health Sciences, Law, St. Thomas More and Main Libraries. Electronic journals and theses were utilized, as were interlibrary loan services for resources not available on campus or electronically. ProQuest Education Journals, Expanded Academic ASAP, ERIC, CINAHL, ISI Web of Science, Canadian Nurses Association NurseONE, and Medline databases were used. Government documents from Statistics Canada, the United States, Britain and Australia were used to provide current statistical information. Key words used in combination in searches included diversity, multiculturalism, minorities, visible minorities, immigrants, equity, professions, health professions, nursing, minority nurses, minority nursing students, Aboriginal nursing students, internationally educated nurses, professional closure, professional elitism, leadership, inclusive leadership, moral leadership, ethical leadership, critical leadership, emancipatory leadership, transformative leadership, authentic leadership, leadership and social justice, leadership as vocation, leadership as calling, motivation of leaders. These search techniques were validated by the Health Sciences Librarian, V. Duncan January 14, 2009, as the most appropriate mechanisms to find literature for this study.

While such techniques appear to be very logical and linear in progression, in fact the process of reviewing the literature also relied on an element of serendipity, as I read widely in the area, and picked up on cues in the environment as a result of my heightened awareness around these key words. Newspaper articles, radio interviews, discussions with Aboriginal elders, and a discussion with a seat mate on an airplane all directed me to some excellent literature and supporting documents which heightened my understanding of these issues.

### **Review of the Literature: Diversity, Multiculturalism and the Politics of Difference**

This section of the chapter reviews the literature addressing the concept of diversity. The chapter addresses the current demographics of diversity in Western countries, and within the health professions. The chapter reviews different frameworks



for addressing diversity, including conservative, pluralistic and critical multicultural approaches. It looks at additional alternative ways of framing, categorizing, and defining the concept of diversity: diversity as social characteristic, societal responses to diversity, and diversity as a policy framework. In looking at diversity from a policy perspective, examples of the differing approaches in Canada and the United States are highlighted.

***The Global Context of Diversity: Globalization, Immigration, and Growth of Aboriginal Populations***

As previously noted, diversity is a significant trend in today's developed world. Statistics Canada reported that visible minorities accounted for 16.2% of the Canadian population in 2006 (Statistics Canada, 2007). Statistics Canada defined visible minorities as "persons, other than Aboriginal persons, who are non-Caucasian in race or non-white in colour" (2001, p. 3, 11). The rate of growth for visible minorities in Canada is greater than that of the general population, and is increasing. In 1991, 9.4% of the Canadian population was considered to be visible minority. By 2001, this number had increased to 13.4%. The visible minority population in Canada increased between 2001 and 2006 at a rate of 27.2%, five times faster than the increase for the population as a whole, at 5.4% (Statistics Canada, 2007).

Immigration accounts for a significant portion of the visible minority population in Canada. Immigration is the most significant source of Canadian population growth. In 2006, 6.3% of Canada's population was made up of immigrants who had arrived in Canada in the last ten years (Human Resources and Social Development Canada [HRSDC], 2008).

Canada's immigration rates are high in relation to many other countries. In the last three months of 2006, Canada accepted 58,300 immigrants, the largest fourth-quarter total since 1992 (Statistics Canada, 2007). Immigrants tend to settle in large urban centers, creating pockets of significant diversity. Notably, in 2006, 45.7% of Toronto's population and 39.6% of Vancouver's population were foreign born. In Calgary, in 2006, 23.6% of the population was foreign-born (HRDSC, 2008).

Three quarters of the immigrants who arrived in Canada between 2001 and 2006 were from visible minorities. Statistics Canada predicts that, at the current rate of growth,

visible minorities will account for one-fifth of the Canadian population by 2017 (Statistics Canada, 2008). Of those who immigrated in the 1990's, 58% were born in Asia, 20% in Europe, 11% in the Caribbean, and Central and South America, and 3% in the United States (Statistics Canada, 2008). Contemporary immigrants come from a broader range of countries and more diverse cultures than ever before (Statistics Canada, 2008).

In addition to the immigrant and visible minority population, the Aboriginal population in Canada continues to grow at a rate greater than that of the total Canadian population. Between 1996 and 2006, the Canadian Aboriginal population grew by 45%, almost six times faster than the non Aboriginal population which grew at a rate of 8% (Statistics Canada, 2008). In the Canadian province of Saskatchewan, where I have worked for the last 35 years, Aboriginal people made up 14.9% of the population in 2006 (Statistics Canada, 2008). The large and rapidly growing population of Aboriginal people in Saskatchewan, and the importance of the health care system and health care professionals in Saskatchewan respecting and addressing the needs of this growing population provided incentive in my choice of this topic for my research.

Increasing population diversity is also seen in other English-speaking countries. Immigration accounts for this diversity in most Western countries. Canada, the United States and Australia are considered the three “classical” immigration countries (Walter & Duncan Gordon Foundation, 2005).

The number of immigrants in the U.S. increased 16% in the five years prior to 2006 (Camarota, 2007). Immigrants accounted for one in eight of the U.S. population in 2007, the highest proportion in 80 years (Camarota, 2007). Most of these immigrants came from visible minority groups. The multicultural makeup of the U.S. is demonstrated by the 2000 U.S. census figures, which showed that 30% of the U.S. population belongs to non-white ethnic or racial groups (Office of Minority Health, 2006).

In the United Kingdom, immigration accounted for half of the population growth between 1991 and 2001 (Vertovec, 2006). In 2005, 7.5% of the British population was born abroad (Kyambi, 2005). As is the case in Canada, British immigrants now come from a much broader range of source countries than in the past, and contribute

significantly to the diversity of the population. Oxford anthropologist Steven Vertovec dubbed the trend to increased diversity *super-diversity* (Vertovec, 2006).

Immigration plays an even greater role in creating a diversity population in Australia than it does in Canada, the United States, and Britain. In the year ending June 30, 2008, overseas immigration accounted for 59% of Australia's population growth. In 2008-09 about 300,000 new migrants were expected to arrive in Australia, the highest number since World War II. As of 2006, 23.9 percent of Australia's population was born overseas (Commonwealth of Australia, 2008).

Australia's diversity experiences, like Canada's, relate not only to their immigration statistics, but also to the presence of an Indigenous population. In 2001, Australian Aboriginals made up 2.4% of the Australian population. This number represented a 16% increase over the 1996 census, and followed an increase of 17% between 1986 and 1991, and 33% between 1991 and 1996 (Australian Institute of Health and Welfare, 2003). While the Australian government attributed some of this increase to better census techniques and increased willingness on the part of Australian Aboriginal people to acknowledge their Aboriginal heritage, approximately three quarters of this increase was believed to be related to actual demographic changes (Australian Institute of Health and Welfare, 2003). Increasing social diversity is, therefore, an international phenomenon, one to which all involved countries and their social structures and institutions are challenged to respond if social justice is to be achieved.

### ***The Health of Immigrants, Visible Minorities and Aboriginal People***

Government and health care organizations in the English-speaking world have identified diversity in society as a major challenge facing the health care system. As noted in Chapter One, the United States Symposium on Diversity in Health Professions (Nickens & Smedley, 2001) determined that many minority groups tend to be less healthy than the majority of U.S. citizens, and often receive lower quality and quantity of health care.

In their study of the health of Canadian immigrants, Newbold and Danforth (2003) found that immigrants tended to experience greater health problems, greater barriers to access to health service, including language and cultural barriers, greater

unemployment and underemployment, and limited economic opportunities in comparison with non-immigrant Canadians. Cardozo and Pendakur (2007) indicated that visible minorities and visible minority immigrants in Canada are at much greater risk of living in poverty than their Canadian-born white counterparts. Poverty and unemployment, or under-employment, are traditionally considered social determinants of the health of populations. Lynam and Cowley (2007) attributed the health and social inequities experienced by immigrants in Britain and Canada in their study to marginalization and marginalizing practices, rather than to innate predisposition to illness.

It should be noted that immigrants are not a homogeneous group in Canada. For example, the health of refugees is considerably lower than other new arrivals (Newbold, 2009), and differences exist in the health status of immigrants based on country of origin, socioeconomic status, racial discrimination and the selection processes used in immigration policy (Nazroo, 2003).

Such health disparities are also seen in Indigenous populations. Ring and Brown (2003) noted that the gap in life expectancy between Indigenous and non-Indigenous populations is estimated to be 19-21 years in Australia, 8 years in New Zealand, 5-7 years in Canada, and 4-5 years in the United States. While this gap is narrowing, serious health issues continue to impact Indigenous peoples around the world.

Many authors and organizations have called for an increase in the number of Aboriginal, visible minority and immigrant health practitioners as a mechanism to address these health disparities (Nickens & Smedley, 2001; Ring & Brown, 2003). In the U.S., both the Sullivan Commission report *Missing persons: Minorities in the health professions* (Sullivan et al., 2004) and the Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Healthcare Workforce [CIPSIDUSHW] document *In the Nation's Compelling Interest: Ensuring Diversity in the Health-care Workforce* (2004) acknowledged that U.S. minority groups experience significant health problems that are not adequately addressed by the current system, and proposed increased diversity in the health professions as a mechanism for addressing these concerns. Nickens and Smedley (2004) subtitled their book on enhancing the diversity of the health profession, *The Right Thing to Do--The Smart Thing to Do*.

As outlined in Chapter One, similar concerns exist in the Canadian context. As noted previously, Canada and the U.S. both continue to experience an unmet goal with respect to increasing minority participation in the health professions. Recently the Association of Faculties of Medicine of Canada (AFMC) released a report calling for enhanced admission requirements and changes in approaches that would ensure that the medical profession recruited, selected and supported a representative group of medical students in order to achieve the desired diversity within the physician workforce (AFMC, 2010). The report noted

Evidence is mounting that today's medical students increasingly hail from the highest income earning families in Canada. Parallel to this, little progress has been made in attracting applicants from First Nations, Inuit, and Métis communities and rural areas. Other sociocultural and economic groups are also underrepresented. (p.18)

A discussion of the demographics of the nursing profession with respect to diversity is included in the section of this chapter called *Nursing and Difference*.

### ***Approaches to Diversity and Difference***

This section of the chapter addresses the concept of diversity from several perspectives. It differentiates between conservative, pluralistic and critical approaches to difference, and addresses societal responses to difference. It discusses diversity as a social characteristic, and as a policy initiative.

#### ***Conservative, Pluralistic, and Critical Multicultural Approaches***

Vedoy and Moller (2007) indicated three major paradigmatic approaches to diversity: *conservative* approaches, *pluralistic* approaches and *critical multicultural* approaches.

*Conservative* approaches were based on biologically determined views of difference. The goal in addressing difference from a conservative worldview is one of "...extinguish[ing] the minorities' differences from the majority" (Vedoy & Moller, 2007, p. 60) through assimilation. Such solutions do not provide minority access to majority privilege.

*Pluralistic* approaches, in response to conservative approaches, recognized minority culture, language and difference, and built policies and programs that supported

the maintenance of such diversity. Ethnic and racial differences were seen as questions of “identity”, and societal actions were deemed necessary to support, maintain, accommodate and value these identities (Kirkham & Anderson, 2002).

Kirkham and Anderson (2002) equated pluralistic approaches to concepts of cultural pluralism and *multiculturalism*. Canadian political philosopher Will Kymlicka, who has written extensively in the area of the needs of underrepresented minorities, equated the terms multiculturalism, minority rights, politics of difference, identify politics and the politics of recognition, indicating that, although they may have slightly different foci, they deal with the same issue, that of addressing the issue of group differentiated rights (Kymlicka, 2002). Group differentiations commonly addressed in the literature were not restricted to race and ethnicity, but included social class, gender, language, sexuality, and physical and mental status.

In addition, Kirkham and Anderson (2002) critiqued multiculturalism for its tendency to set apart difference as “exotic” and “strange.” They saw limits to the focus on celebrating the unique identity of minorities in the way multicultural approaches did, believing that defining groups by their identifying characteristics provided a static representation of them that failed to address the historical and political questions that have contributed to the current societal role occupied by such groups.

Critics of pluralistic approaches maintained that these approaches did not recognize the power relationships between minorities and majorities and that these power differentials must be addressed and compensatory actions taken (Kirkham & Anderson, 2002; Ryan, 2003; Vedoy & Moller, 2007). Browne (2001) saw pluralistic approaches as failing to question structural injustices, remaining content to maneuver within them. Critics advocated a *critical multicultural* approach, based on principles of social justice (Dewey, 1936; Freire, 2000) and democratic leadership (Furman & Starratt, 2002).

The term *critical* appears in several contexts in this study. By *critical* approaches, I mean approaches that incorporate concepts of power, critique of the status quo, and societal transformation toward a more just society. Approaches used in this study were primarily informed by the social justice approaches of critical multiculturalism. Critical multiculturalism is explored in more detail later in the chapter.

### ***Societal Responses to Diversity***

Harper (1997) described five historical societal responses to difference: suppressing difference; insisting on difference; denying difference; inviting difference; and critiquing difference.

*Suppression of difference* stems from strong belief in the superiority of the dominant culture, and assumes that difference can be eliminated through assimilation. Mechanisms such as the legislation of residential schooling were employed for the purposes of assimilating and eliminating cultural differences.

*Insisting on difference* as a societal response is predicated on the belief that difference is "...natural, predetermined and unassailable" (Harper, 1997, p.192). Accommodation is required, usually through separate and distinct systems, such as segregated school systems for groups including Afro Americans, women and the disabled. The assumption underlying these accommodations is the belief that traditionally, members of such groups require different education.

The response to *deny difference* is the counter-position to insisting on difference (Harper, 1997). Denying difference, according to Harper, ignores or minimizes difference, and requires equal treatment for all. This position is based on notions of equality, rather than equity. Harper viewed this position as based on liberal notions of human identity as a "...unified, rational essence that transcends race, gender, and other forms of difference... Because identity is not determined by, for example, femininity or blackness, such characteristics should not be considered..." (Harper, 1997, p. 192). This approach assumes that we are all "just folks". Harper saw this "color-blind" approach as side-stepping the issues related to difference.

The response of *inviting difference* is based on a culturally pluralistic celebration of the mosaic of difference. This approach of honoring and accommodating identity is the core of Canada's policy approach to multicultural policy, which is discussed later in this chapter.

*Critiquing difference* goes beyond the recognition and celebration of difference to interrogate inequalities and examines issues of power and powerlessness in society. Critiquing difference "... highlights the relationship between personal prejudices and

systemic discrimination, exposing ways in which social structures limit some [individuals] and advantage others” (Harper, 1997, p. 201).

Harper’s description of societal responses to difference is useful in the context of this study, in exploring some of the traditional approaches to difference found in the nursing literature, and also in understanding the stories of the study participants’ experiences with difference in Chapter Four.

### ***Diversity as a Social Characteristic***

An alternative way of framing diversity involves describing how diverse groups relate to the majority. Winterdyk and King (1999) described diversity as a social characteristic, involving four sub concepts: diversity as *heterogeneity*, diversity as *social stratification*, diversity as *social inequality*, and diversity as *minority group status*.

*Heterogeneity* as a social concept, according to Winterdyk and King (1999), structures social interaction. Members of larger social groups experience fewer interactions with other groups than do members of smaller groups. Therefore they are less experienced in interaction with other groups than are members of smaller groups.

The second concept describing diversity is that of diversity as *social stratification*. Social stratification approaches introduce the concept “that socially prescribed differences often result in status distinctions” (p. 5). As a consequence of socially stratified diversity, individuals from diverse groups are ascribed social status based on membership in that group.

Third, diversity as *social inequality* exists when social status is reinforced through use of social power (Winterdyk & King, 1999). Social power is rarely seen in its direct expression, but is usually expressed by more indirect approaches such as group customs and traditions, as well as control over procedural laws and standards.

The fourth social characteristic of diversity according to Winterdyk and King, relates to diversity as *minority group status*. According to Winterdyk and King (1999) “A group is a minority group when its members are socially disadvantaged because of a common physical or socially prescribed characteristic. The social disadvantage based on minority group status represents a form of collective discrimination against those in the minority by the dominant group” (p. 8).



Diversity as minority group status goes beyond the previous characteristics. Dominance is not based on the relative size of the group, but on maintenance of social power.

Such characterizations of the social characteristics of diversity were helpful in the conceptualization of this study, and the analysis of the stories of participants, as they helped to situate the experience in minority groups as a socially situated experience growing out of social power relationships.

***Diversity as a Policy Framework: American and Canadian Approaches to Diversity***

Researchers looking at the experiences of underrepresented minorities are obliged to consider the context in which these experiences occur. The literature in this area revealed some significant differences in approach in Canada, as compared to the U.S. In order to understand these differences in approach, one needs to take a closer look at the concept of *multiculturalism* from a *policy* perspective. It is particularly important to understand Canada's social and political approaches to difference, and the differing approaches taken in the U.S. context.

As Kirkham and Anderson (2002) indicated, multiculturalism is not only a concept; it is a policy approach which has been adopted by the governments in countries such as Canada and Australia to manage cultural diversity. *Multiculturalism* as a policy concept grew from the need to address the specific needs of minority populations.

The term 'multiculturalism' emerged in the 1960's in Anglophone countries in relation to the cultural needs of non European migrants. It now means the political accommodation by the state and/or dominant group of all minority cultures defined first and foremost by reference to race or ethnicity; and more controversially, by reference to nationality, Aboriginality, or religion... (McLean & McMillan, 2003, pp. 354-5)

The United Nations Educational, Scientific and Cultural Organization (UNESCO) described multiculturalism as a policy approach in its 1995 paper *Multiculturalism: A Policy in Response to Diversity*. Multiculturalism is described as the need to "[cope] with the management of ethnic and cultural diversity through policies which promote ethnic and cultural minority groups' participation in, and access to the resources of society, while maintaining the unity of the country" (p. 2).

Multicultural approaches to difference were developed on a large scale political policy level in Australia and Canada. These policies were a “systematic and comprehensive response to cultural and ethnic diversity, with educational, linguistic, economic, and social components and specific institutional mechanisms” (UNESCO, 1995, p. 2).

Canada’s national multiculturalism policy was introduced in 1971. The policy evolved into the *Canadian Multiculturalism Act* of 1988, with goals of promoting race relations, enhancing cross-cultural understanding and ensuring equal participation of ethnic minorities in Canadian life (Chan, 2007). Some authors noted that Canada’s implementation of a multiculturalism policy is linked directly to its commitment to a human rights framework as a societal way of functioning. A human rights framework “is based on the belief that everyone has inalienable rights to housing, food, education and health care, and that society must provide these for those unable to provide for themselves” (Ore, 2006 p.4). Canada’s commitment to a human rights agenda is embodied in its Charter of Rights and Freedoms, which was entrenched as Chapter 11 of the *Canadian Constitution*, in 1982.

Canada’s diversity model relates to values of equity and inclusion. Lyman and Cowley (2007), in their study of immigrants in Canada and Britain, stated that Canada’s formal commitment to multiculturalism at a policy level was significant to their participants, reporting that “The perception that their place was one for which there was an historical precedent seemed reassuring. Having formal opportunities to participate in society is ... important” (p. 146). However, their study also noted that these immigrants reported marginalization and racism in their daily lives. Lyman and Cowley (2007) concluded:

Although, when mobilized, legislative rights can foster inclusion these must also be considered in relation to competing discourses. These data suggest that contradictory messages about “place” exist alongside formal mechanisms for participation in democratic societies. Such contradictions create tensions and when unchallenged, unacknowledged or unexamined augment the experience of being on the margins. (p.146)

While the operationalization of multicultural policy in Canada is not without significant problems and limitations, Adams (2003), in his study of the societal

differences between Canada and the U.S. described Canada as a country lacking a tradition for intolerance of difference. There is a range of commitment to the concept of diversity at a societal level, from tacit acceptance of multiculturalism as a societal concept and a policy framework, to passionate commitment to diversity as a moral imperative (Winterdyk & King, 1999). Harper noted, somewhat critically, that multiculturalism is seen by some as “the very essence of Canadian identity” (1997, p. 193).

By contrast, the American literature on diversity is embroiled in controversy (Orfield & Kurlaender, 2001). This controversy is most easily seen in the policy debate around affirmative action, the term in the American vernacular that has become synonymous with diversity and multiculturalism. The literature addressing affirmative action in U.S. education was reviewed here as a contrast to the policy commitment to diversity in the Canadian context.

Diversity as a concept was thrust into the limelight in the U.S. in June, 1978 when Justice Lewis Powell ruled in the Supreme Court case of *Regents of the University of California v. Bakke* that the goal of attaining a diverse student body provided a constitutionally permissible reason to allow race as a consideration in admission to medical school (Wood, 2003). This ruling overrode the Fourteenth Amendment of the United States constitution guaranteeing equal protection under the law, and created the popular use of the term *diversity* as a code for mechanisms (positive, or *affirmative* actions) to increase participation of groups formerly underrepresented in education and industry.

It is important to note that the legal support for affirmative action in the United States was not based on the principle of justice, as a way of righting past wrongs. In the Supreme Court ruling on the Bakke ruling of 1978, affirmative action was justified, not to right past wrongs but in order to increase the diversity of a student body or workplace, and thereby increase the nature of the discourse and experiences in the classroom or workplace as a result. In effect, fairness (correcting past injustices) was not significant as the underlying value driving the decision. Improved function (the creation of a more

diverse and interesting student body), was the primary driving force behind the decision (Dale, 2005).

Prior to the election of President Obama in the United States in 2008, there had been a full-scale attack on affirmative action in the U.S. (Orfield & Kurlaender, 2001). In the face of this backlash, proponents of affirmative action in education defensively argued that the educational value of diversity is sufficiently compelling to justify consideration of race as a factor in deciding whom to admit to colleges and universities (Orfield & Kurlaender, 2001). Opponents of affirmative action, however, saw the concept of diversity as a threat to the existence of democracy in the U.S. The privileging of diversity, Wood argued, maintained fragmentation which did not allow America to come together (2003). Wood commented “The new movement is...a repudiation of the older attempts to find a oneness in our many-ness. *Diversity* in its new form tends to elevate many-ness for its own sake” (p. 8). He went on to say:

The new perspective of *diversity* is not just about emphasizing groups at the expense of the whole; it is about treating groups as having saved up a right to special privileges in proportion to how much their purported ancestors were victimized in the past. This quid-pro-quo has become a quasi principle that aims to encompass American life. ...But it is more than a matter of government mandates. The *diversity* principle is also a *belief* that the portion of our individual identities that derives from our ancestries is the most important part, and the feeling that group identity is somehow more substantial and powerful than either our individuality or our common humanity. (pp. 10-11)

Nieto (2004) found these views echoed in the education system, where opponents of diversity believe that differences “get in the way of learning.”

The literature addressing diversity in the United States context was often funneled in focus to the task of either condemning or defending affirmative action, and, as such, took on a narrow, legalistic policy approach to the topic.

This discussion of multicultural policy approaches demonstrates the differences in approach between the United States and Canada. While Canada’s policy approach supports the pluralistic view of multiculturalism in acknowledging and managing difference, Wood’s writing offers a contrasting picture of the perceived threat in the U.S.

posed by acknowledging “manyness,” and the importance of eliminating difference through conservative approaches to multiculturalism.

While it is important not to reduce this dichotomy of policy approaches to difference to a symbolic, simplistic and essentializing “Canada good - U.S. bad” conclusion, this review of the U.S. literature on diversity and affirmative action was included here to demonstrate the divergence in perspectives on difference between Canada and the U.S. at a policy level, and to provide a context for some of the differences between the U.S. and Canadian literature included in this study.

### ***Critical Multiculturalism***

In this section of the chapter, the concept of critical multiculturalism introduced earlier in the chapter, is explored in more detail. The critical approach to difference assumes that difference is not biologically or culturally determined, but is a socially constructed concept. Ceci (2006) saw difference as a relational concept, with meaning in any particular situation dependent on relationship and context. Difference is created, socially stratified, and transformed into systems of inequality for the purpose of advantage gained by the dominant societal group at the expense of others (Johnson, 2006; Ore, 2006; Winterdyk & King, 1999). Johnson indicated that “Those [members of society] who are disadvantaged ...do not have the social power to define their condition as within the boundaries of normality...” (2006, p.19).

Kymlicka (2002) indicated that, while minority groups may not possess social power, they are no longer content to accept the manner in which their conditions are defined:

Modern societies are said to be characterized by deep diversity and cultural pluralism. In the past, this diversity was ignored or stifled by models of the ‘normal’ citizen, which were typically based on the attributes of the able-bodied, heterosexual, white male. Anyone who deviated from this model of normalcy was subject to exclusion, marginalization, silencing, or assimilation...

Today, however, previously excluded groups are no longer willing to be silenced or marginalized, or to be defined as ‘deviant’ simply because they differ in race, culture, gender, ability, or sexual orientation from the so-called normal citizen. They demand a more inclusive conception of citizenship which recognizes (rather than stigmatizes) their identities, and

which accommodates (rather than excludes) their differences. (2002, p. 327)

Kymlicka (2002), drawing on the work of critical theorist Nancy Fraser, indicated that the injustices resulting from minority under-representation generate two types of responses: the *politics of redistribution*, which focus on socioeconomic injustices including exploitation, economic marginalization and economic deprivation, and require public policies to redistribute economic opportunity; and the *politics of recognition*, which focus on cultural injustices, including cultural domination, non-recognition and disrespect, and require cultural change to “upwardly revalue disrespected identities and cultural products of maligned groups, or positively value cultural diversity” (Kymlicka, 2002, p. 333). Kirkham and Anderson (2002), in referencing Fraser’s work, suggested that the central notion of this view, common to both responses, is *parity of participation*, meaning that “...justice requires social arrangements that permit all (adult) members of society to interact with one another as peers” (p. 327). Participation becomes the objectification of justice.

Although the concept of difference at the center of this study may be considered by some to be racial and ethnic in nature (immigrants, visible minorities and Aboriginals), difference for the purpose of this study was viewed from the critical perspective of power and domination, rather than restricted to culture, race or ethnicity. Difference for the groups addressed in this study (Aboriginal people, visible minorities and immigrants) occurred not because members of these groups were from different ethnic or cultural groups per se, but because of their position of power in society in relation to that of the majority. Difference was not racially determined, but was dependent on power and social structures. The practice of defining difference based on racial characteristics is defined as the *racialization of difference*. Further discussion around the limitations of the cultural approach to difference occurs in the section of this chapter on *Nursing and Difference*. The racialization of difference is also addressed in the section on *Race, Ethnicity, and Difference* found in the *Nursing and Difference* section of this chapter.

Thus we see diversity as an issue that must be addressed in policy at a political level, but also in interaction at the interface of daily life. It was the experiences of nursing leaders at both of these levels that this study explored, and it is for that reason that this review of the literature was included in the study.

***Asset Based Approaches to Diversity: Communities of Difference***

The previous discussions of diversity and multiculturalism focused on the deficiencies that result from under-representation of minorities. Words such as disrespect, domination, deprivation, injustice, disadvantage and inequality typify *deficit-based* approaches to the question of difference. Solutions to the “problem” of difference are directed at achieving, for the underrepresented groups, that to which the majority already has access. The literature largely viewed diversity from a deficit-based perspective. Differences were to be accommodated to address *deficits* that occurred as a result of structural conditions ranging from benign lack of opportunity, through to overt discrimination and hegemony at the hands of oppressive dominant groups, depending on the paradigmatic views of the authors. Deficit-based approaches to difference advocate compensation for deficiencies in societal opportunities for underrepresented groups, specifically in the areas of education and employment.

There is a body of literature in the educational administration field that advocated for the creation of *communities of difference*. The approach taken by communities of difference writers was much more celebratory, as seen in this quote from Carolyn Shields (2004a):

Although we generally think of *community* in terms of what binds participants together—shared norms, beliefs, and values—communities of difference are based not on homogeneity but on respect for difference and on the absolute regard for the intrinsic worth of every individual. Members of such communities do not begin with a dominant set of established norms but develop these norms together, with openness and respect, as they share their diverse perspectives. (p. 38)

Advocates of the communities of difference approach rejected traditional uses of the term *community*:

Community, used in such ways, signifies *smoothing over* differences, *uniting* a divided people, *healing* a broken nation, and *making morally responsible* those who are deemed self-centered rights-chasers. Individual

differences within such notions of community are tears to be mended or bumps to be smoothed. (Abowitz, 1999, p.144)

Communities of difference stress the *assets* contributed by such difference:

...if we cannot imagine community without imagining how human differences can peacefully co-exist and even thrive in its organic and shifting borders, then we will find ourselves hard-pressed to build social alliances across the constructed lines of social identity that currently keep us segregated and in violent conflict. (Abowitz, 1999, p.144)

Asset-based approaches appear again later on in the chapter in relation to concepts of difference discussed in the nursing literature. Literature about asset-based approaches to difference was included in this literature review because of the appearance of asset-based approaches to difference in the stories of the study participants.

### ***Nursing and Diversity***

This section of the chapter begins with a discussion of the demographics of diversity in nursing, and the background to the issue, including experiences of minority nurses and nursing students. A theoretical discussion of the concept of diversity in relation to the profession follows. As previously noted, there was limited nursing literature available that addressed theoretical perspectives of diversity within the profession. The nursing literature on difference and diversity was almost exclusively focused on the recipients of nursing care, and did not look extensively at theoretical perspectives on difference within the profession. In the absence of literature on difference within the profession, I examined the writings of the profession with respect to client diversity. This literature was largely written from a cultural perspective, rather than from the critical multicultural perspective used in this study. Literature critiquing these cultural approaches in nursing was explored. Following this critique, I looked more closely at the nursing literature addressing race, ethnicity, and racism. The nursing literatures relating to the concepts of *marginalization* and *othering* were included, as these concepts incorporated an understanding of power and power relationships that were consistent with this study.



### ***Immigrants, Visible Minorities and Aboriginal People in Nursing***

International nursing organizations acknowledge that nursing does not represent the ethnicity and diversity of the general population (ICN, 2004a; ICN, 2004b). However, as noted in Chapter One, nursing has been one of the health professions most successful in meeting the challenge of increasing diversity. In 2007, 25.9% of nursing students in the U.S. were from minority groups (American Association of Colleges of Nursing [AACN], 2008).

The U.S.-based 2001 Symposium on Diversity in Health Professions indicated that nursing was in a unique position to increase participation of underrepresented minorities (URMs) for two reasons: it was the only health profession that did not require a baccalaureate degree for initial licensure to practice, and it had several different educational entrance points into the profession, in the form of diploma, associate degree, and baccalaureate degree credentials (Grumbach et al., 2001). While this was true historically, there is a significant move internationally to make the baccalaureate degree the entry point into the profession, and to phase out diploma programs. In Canada, in the academic year 2007-2008, only 22% of students enrolled in entry to practice education programs were enrolled in diploma programs (CNA/Canadian Association of Schools of Nursing [CASN], 2009).

While statistics on minorities in nursing are available in the U.S. context, it was not as easy to determine minority participation in nursing in Canada, as Canadian statistics on ethnic and racial makeup of the health care professions are not collected in the same manner as the United States. There is, however, general agreement that the makeup of nursing is not representative of the Canadian public (ICN, 2004; CNA, 2008; Villeneuve & MacDonald, 2006). As previously noted, nurses in the western developed world are predominantly white, middle class, and female (Chua & Clegg, 1990; Huston, 2006; Newell-Withrow & Slusher, 2001; Page & Thomas, 1994).

McPherson (1996) described the historical development of nursing in Canada. She demonstrated that nursing has historically limited the participation of minorities, relegating them to lower status ancillary positions.

...divisions among nurses were solidified by educational requirements dictating that women with fewer personal and social resources, whatever

the function of their class background, immigrant status, or racial category, were concentrated in the lower levels of the nursing hierarchy. Differences of class origin, nativity, and ethnicity, manifest in differential access to training programs and jobs, reinforced the privileged positions on RNs over subsidiary workers. (pp. 224-225)

Current international data supports this historical trend. Immigrant, visible minority and Aboriginal nurses are over-represented in entry level positions, less successful in job applications and are not represented in leadership positions (ICN, 2004). In addition to limited participation of immigrants and visible minorities in Canadian nursing, there is limited participation by Aboriginal people in the profession. Of the 252,000 nurses in Canada in 2003, it was estimated that there were between 1000 and 1200 of Aboriginal ancestry in 2003 (National Aboriginal Health Organization, 2003). A national task force conducted in Canada in 2002 and updated in 2007 found that the overall number of Aboriginal nursing students increased from 237 in 2002 to 730 in 2007, an increase of 493 students (Gregory, 2002; Gregory, 2007). However, the 2007 numbers represent only 1.27% of the total number of nursing students in Canada (CNA/CASN, 2008). The number of Aboriginal nursing students would need to triple to accurately reflect the 3.8% of Canada's population that is Aboriginal (HRSDC, 2008).

Canadian and international nursing organizations and leaders have repeatedly called for the creation of a diverse nursing profession (American Association of Colleges of Nursing [AACN], 1997; CNA, 2008a; Villeneuve & Macdonald, 2006; Wilson, Sanner, & McAllister, 2003). Despite the support of national professional organizations to increase the participation of underrepresented minorities in their ranks, growth in numbers is slow. To understand why, I looked at the experiences of immigrant, visible minority and Aboriginal nurses and nursing students.

### ***The Experiences of Minority Nurses***

Minority nurses experience personal and systemic barriers, whether they enter a country as immigrant nurses educated in foreign countries, or are educated in the host country (Etowa et al., 2005; Hagey, 2005; Hassouneh, 2008; Jeans et al., 2005; Jeans, 2006). The experiences of two specific groups of minority nurses were explored next: The experiences of immigrant nurses educated in foreign countries, and the experiences

of minority students in nursing education, with specific attention to the experiences of Aboriginal nursing students in Canada. There was extensive literature in nursing about the barriers experienced by Aboriginal, visible minority and immigrant students in nursing, and a growing body of literature on the experiences of internationally educated nurses registering and practicing in North America, Australia and the United Kingdom. However, most of this literature dealt with personal barriers and personal solutions, rather than addressing structural barriers and systemic solutions. In the interests of brevity, most of the examples used to describe these experiences were in the Canadian context, with occasional references to other jurisdictions.

### ***Internationally Educated Nurses***

Many countries, including Canada, have looked to the recruitment of internationally educated nurses (IENs) in an effort to address significant global nursing shortages (ICN, 2004). While only 10% of Canada's nurses in 2006 were internationally educated (Jeans, 2006), the number of applicants is growing. In the recent past, the Saskatchewan Registered Nurses Association received between 55–75 applicants from IENs yearly. In 2007, 250 applications were received (Hamilton, 2008), as compared to 856 applications in 2008 and 718 in 2009 (Saskatchewan Registered Nurses Association [SRNA], 2009). In March 2008, The Government of Saskatchewan, in partnership with health care, nursing and nursing education organizations, went to the Philippines to recruit 300 Filipino nurses in an effort to address Saskatchewan's nursing shortage (Government of Saskatchewan, 2008).

Given the severe global shortage of nurses and the active recruitment of IENs by many host countries, one would assume that IENs would have been welcomed into practice in their new countries with open arms. This was not the case. IENs experienced significant barriers in attempting to register and work in the recruiting countries. For example, authors reported that less than one third of IEN applicants in Canada ultimately met the language and educational requirements to be licensed to practice (Coffey, 2006; Jeans, 2006). The ICN outlined the barriers faced by IENs as follows: qualification assessment/ recognition; registration requirements; immigration/ work restrictions; prejudice; and integration (ICN, 2004).

**Qualification assessment and recognition.** The lengthy, expensive, decentralized, obfuscated processes for nurse registration in Canada constituted major barriers to successful licensure and practice for IENs (Jeans et al., 2005; Jeans, 2006; Lebold & Walsh, 2006; McGuire & Murphy, 2006). Jeans (2006) outlined significant challenges in three areas: information, documentation and education. With respect to information, because licensure of registered nurses is a matter that is regulated provincially, rather than a federally determined process, there is no central place where reliable information can be gleaned with respect to attaining licensure in Canada. Applicants often contacted the Canadian embassy or High Commission in their country of origin for information (Jeans, 2005). There was frequently no information available. Information, when provided, was often wrong.

Nursing is a self-regulating profession in Canada. As noted above, licensure is governed by ten different provincial government acts and three territorial acts, as well as provincial and territorial professional regulatory body bylaws. Requirements differ from province to province. For example, most Canadian provincial nursing bodies moved to require a baccalaureate degree for entry to practice in recent years. However, some provinces still accept applicants with diploma qualifications. As a result of these changing and diverse requirements, many IENs arrived in Canada unaware of the educational requirements in the province to which they are relocating (Coffey, 2006). They may have followed the correct application procedure, but for the wrong province, and thereby had their applications denied. Applicants were often unaware that their applications may in fact meet requirements in another province (Jeans, 2006).

IENs faced a bewildering process of documentation, including credential assessment and registration (Jeans, 2006; McGuire & Murphy, 2005). Differing processes of credential assessment are used by each province. Credential assessment involves reviewing documents measuring competencies, evaluating practice experience, assessing educational equivalencies, and assessing equivalency of credentials (Jeans, 2006). In some situations, documentation may need to be original; in other situations copies are satisfactory. In addition, a national study in 2005 determined that ten different language

tests were being used as proof of language proficiency for IEN registration across Canada (Jeans, 2005).

Maguire and Murphy (2005) noted that language barriers and differing cultural practices result in confusion, delays, repeated submissions and frustration. Jeans et al. (2005) found that the cost of the assessment process varies widely across the country, estimating it to range from \$1000-\$20,000.

The varying types of educational programs which were praised by Grumbach et al. (2001) in Chapter One as facilitating entry for members of under-represented minorities, actually served as barriers for IENs. With the move to baccalaureate degree as the entry point to practice, many foreign-educated nurses who graduated from diploma programs or secondary school nursing programs (as seen in Mexico, China, and Eastern Europe) in their home countries are not eligible for practice in Canada (Edwards & Davis, 2006). As the move to baccalaureate degree as the entry to practice has been relatively recent, occurring in different provinces at different times over the last ten years (Davidson, Dick & Cragg, 2006), many IENs were unaware of the changed requirements (Coffey, 2006), or began the registration process under the former requirements.

IENs are required to enroll in educational programs to upgrade their credentials to the level of the degree. Traditional bridging programs have not proved successful, necessitating the development of specialized bridging programs specifically designed for IENs. These programs include in their curricula the development of test-taking skills in English, and specific preparation for the nation licensure exam, the Canadian Registered Nurse Examination [CRNE] (Coffey, 2006; Jeans, 2006). Such programs are expensive, for both the educational institution and the IEN student.

The issues in qualification assessment and recognition were summed up by Socan and Singh, 2007:

Nurses are also cited as specific case examples within larger discussions of the international exploitation of healthcare professionals following their arrival in their countries of destination. Iredale (2001) approaches the difficulty of nursing registration from the perspective of the receiving nation's monopoly on professional entry requirements, thereby determining the milestones through which foreign professionals must advance in their quest to be recognized as competent practitioners in their new country. IENs are often downgraded into lower professional

classifications, which results in knowledge and skills exploitation by their new employers, while at the same time, being compensated for professional services at lower rates of pay than they would normally be entitled to. IENs believe that they are not respected, nor their qualifications recognized as valued. (p.131)

**Registration requirements.** Internationally educated nurses are required to write the Canadian Registered Nurse Examination in order to register in all provinces of Canada (except Quebec, which has alternate registration examination requirements). IENs have traditionally experienced high failure rates on the Canadian registration exam. Between 2000 and 2006, internationally educated candidates had pass rates ranging from a low of 49% in 2004 to a high of 68% in 2006. In the same period, the lowest pass rate among Canadian-educated writers was 93% in 2003, and the highest was 96% in 2005 (CNA, 2009).

In an attempt to increase the success rate for licensure, Health Canada supplied funding for support programs. The Ministry of Health in the province of Saskatchewan received \$2.18 million dollars for 2006-2010 to "...facilitate the development of a comprehensive range of essential tools, products, and services for internationally educated health professionals, designed to improve their chances of attaining licensure and ultimately employment in health services" (Hamilton, 2008, p.10). Such initiatives appeared to have spotty success, as the success rate for IEN first-time writers in 2007 was 71%, but fell to 66% in 2008, and rose again to 77% in 2009 (SRNA, 2009). This rate is slightly higher than the 68% success rate in 2006, prior to the start of increased funding and introduction of support programs. By comparison, the pass rate was 93% for Canadian educated first-time writers in 2008 (CNA, 2009). and 98% for Saskatchewan educated first-time writers in 2009 (SRNA, 2009).

**Immigration/work restrictions.** Maguire and Murphy (2005) noted that one of the significant issues faced by immigrant nurses was the Catch 22 position related to requirements for recent practice. Despite shortages across the country, and active recruitment by many health regions, facilities, and provincial ministries of health, nursing has not been considered a deficit profession on Canada's General Occupation List. (Jeans et al., 2005; Sochan & Singh, 2007) Nurses are often forced to enter the country as

domestic workers or restaurant workers, both of which are considered deficit occupations. They are not allowed to engage in clinical or educational activities until they become landed immigrants, usually a two year process (Sochan & Singh, 2007).

In order to achieve registration as nurses in Canada, internationally educated nurses are required to have recent clinical experience. However, they are not allowed to practice nursing in Canada. Maguire and Murphy (2005) reported that 40% of nurse applicants to an IEN support program in Ontario in 2005 were unemployed, while 15% were employed in non-health care related employment. Thus, while they navigated the lengthy processes of immigration and licensure, they were unable to maintain their nursing skills and meet the requirement for recent practice hours.

**Prejudice.** Turriffin et al. (2002) noted that nursing and nursing research have begun to address the issues of multiculturalism and transcultural nursing, but have done little to address, or even acknowledge, racism within the profession. They argued that multiculturalism in client care cannot be addressed without addressing racism in nursing.

Barbee (1993) noted that “The contradictions between caring, a principle part of the identity of nursing, and racism make it difficult for nurses to acknowledge racial prejudice in the profession” (p. 346). Turriffin et al., 2002 expanded on this view:

We believe that racism is still the R-word in many quarters of nursing, because the term itself connotes an implicit accusation. We offer the concern that anyone’s participation in racism is often difficult to see. Furthermore, its occurrence is sometimes not believed by nurses whose identity is linked with being caring, including caring about equity and fairness in society....we discuss these beliefs as part of an ideology that overlooks discriminatory practices such as the marginalization, harassment and exclusion reported by [immigrant nurses]. (p. 656)

Hagey et al. (2005) reported on experiences of minority nurses in Canada. Their study of 62 minority nurses found that the nurses studied believed that race, ethnicity and color negatively affected relationships with patients, fellow staff, and managers, limited their access to training and education, negatively affected work assignments, and increased the likelihood of poor performance reviews and disciplinary action. They reported being harassed, and that this affected them negatively, both physically and emotionally. Less than half of the participants who had reported these actions to their

employing institutions indicated that any action had been taken to address their concerns (Das Gupta, 2009; Hagey et al., 2005).

In a study of the British National Health Service (NHS), one in three black and minority ethnic (BME) nurses surveyed believed the NHS to be institutionally racist (Harrison, 2004). They reported racist treatment from fellow staff, supervisors and patients. They believed that they had been passed over for promotion and denied opportunities because of their race or ethnic origin. They reported a lack of support from the employing organization when patients refused care and requested other nurses, based on their color or ethnic background. They were divided on whether senior administrative efforts to encourage managers to mentor BME staff were progressive or patronizing (Harrison, 2004).

In a study of 26 ethnically diverse, racially diverse (immigrant, visible minority and Indigenous Maori) New Zealand and U.S. nurses, some of whom were gay or lesbian, (2005b) reported an overarching meta-story in their experiences with racism: the story of *not fitting in to nursing*. These nurses' stories produced the following meta themes: Meta-theme One, *experiencing unfairness*, which involved difficulties getting in to nursing; being "not quite suitable" for nursing (being directed to auxiliary roles such as nursing assistant or aide roles); experiencing assumptions of sameness; experiencing difference taking on symbolic meaning (discrimination based on overt characteristics); experiencing assumptions that "they" are advantaged by their minority status; and intolerance of any creative contributions (viewed as insubordination and deviance).

Meta-theme Two, *trying to survive*, involved leading two lives (keeping their nursing and cultural lives separate); transiting between two worlds; and "living in contradiction and working surreptitiously." *Living in contradiction* involved finding nursing and health care practices contradictory to many of their own cultural understandings, and needing to *live surreptitiously* to practice in accordance with their own cultural understandings, and surreptitiously assisting their minority clients to do the same.

In a study of nursing care teams in a major U.S. metropolitan area, Dreachslin, Hunt and Sprainer (2000) found that racism exacerbated team conflict and



miscommunication and significantly impacted team functioning. Social isolation, selective perception and stereotypes based on race deepened the conflicts and dissatisfaction with team communication that the researchers felt could be expected normally as a result of differing perceptions and alternate realities. Dreachslin et al. indicated that racism in this study served as a kind of professional closure, limiting access to positions of influence on the teams, maintaining closed social systems, and reinforcing social status (2000). The literature surrounding the concept of professional closure is discussed later in the chapter.

**Integration.** Jeans (2006) noted significant differences in cultural practices between the destination country and the country of origin with respect to health, the health care delivery system, and the status and role of health care professionals with the system.

In many cultures, women—and nurses, most of whom are women—are still treated quite differently than they are in developed countries. Religious beliefs and cultural practices may govern the way women and men behave in certain situations. For instance, men and women in some cultures may be required to be on separate floors in a hospital, or women under some circumstances may be permitted to see only female healthcare personnel. When IENs come to us from radically different countries and cultures, they need a great deal of help adjusting generally to the new culture and particularly to the differences in healthcare practices in their new environment. (p.59S)

Maguire and Murphy (2005) found that lack of proficiency in the host country language significantly hindered IENs in navigating the application for registration process, successfully completing the registration exam, and ultimately, in integration into practice. Language subtleties, especially in verbal and telephone communication, and the use of idioms and technical language, were the major areas of concern. Additional issues faced in integrating into practice in the host country include less focus on critical thinking skills and lower use and availability of technology in home country educational programs (Lebold & Walsh, 2006).

These findings were significant in relation to this study because they alerted me as a researcher to these difficulties, and thereby caused me to be aware of such challenges in the stories of my study participants.

### ***Minority Nursing Students***

Much of the current literature about minority nursing students compared the experiences of cultural minority nursing students with students of European white heritage (Abrums & Leppa, 2001). Paterson, Osborne and Gregory (2004) criticized this research approach, believing that culture is objectified and there is often an assumption that all students from the minority culture have the same experiences. They indicated that such approaches generally result in a "...taxonomy of beliefs and practices that support stereotypes and generalizations..." (2004, p. 2). Such approaches ignore the power dynamics and individual aspects of the situation. Those involved become "they" and issues are attributed, resulting in the approach that "that's just the way they are". Difference is seen as a "problem".

Much of the literature addressing the participation of minority groups in nursing education described the *personal* barriers experienced by students: racism, insufficient academic preparation, high drop out rates in high school, limited financial resources, social isolation, and multiple complex personal and social issues (Etowa et al., 2005). Paterson, Osborne and Gregory (2004) were critical of this individual approach to issues. They contended that such an approach ignores the social and political dynamics that lead to such conditions. Strategies to address the "problem" are generally directed at supporting or forcing all students to adopt the values and behaviors of the dominant euro-white, female culture (Paterson, Osborne & Gregory, 2004).

With Paterson, Osborne and Gregory's criticisms in mind, I explored the literature around barriers to minority success in nursing education. The U.S. Sullivan Report, referred to in Chapter One, identified the following barriers existing at a *systemic* level: over-reliance on standardized testing in the admissions process, unsupportive institutional cultures, insufficient funding sources, and leadership without a demonstrated commitment to diversity (Sullivan et al., 2004). This section of the chapter includes a brief discussion of both personal and systemic barriers experienced by minority nursing students. Because of my own extensive experiences with Aboriginal students, and the particular issues faced by Aboriginal students in the Canadian context, I reviewed the literature with respect to experiences of Canadian Aboriginal nursing students.

**Personal barriers.** Yoder (1996), in a grounded theory study of 17 ethnically diverse nursing students identified four areas of student need: personal needs, including financial support, and child care; academic needs for tutoring and study support; language needs; cultural needs, such as ethnic role models and an understanding of the cultural dichotomies faced. Amaro, Abriam-Yago & Yoder (2006) replicated this study, and expanded on the areas of student need. Personal needs of the students in their study included: lack of finances, insufficient time, family responsibilities, and language difficulties. Academic needs included: study workload, the need for tutoring, and the need for study groups. Cultural needs included: communication, assertiveness, and lack of ethnic role models. The most significant barrier experienced was that of prejudice and discrimination, from classmates, faculty, hospital staff, and patients (Amaro, Abriam-Yago & Yoder, 2006).

**Systemic barriers.** According to Grainger (2006), black and minority ethnic students in Britain have less than half the chance of getting in to nursing programs than white students have, and that, even though such numbers are known to nursing education programs, virtually nothing has been done to alter these statistics. Hassouneh (2008) indicated a significant degree of eurocentricity in nursing program curricula. She identified the absence of minority faculty, especially at the senior levels in nursing education, as a significant barrier to minority participation. This absence of minority leadership perpetuates a culture of power with Euro-American faculty at the center and minority students at the margins, and allows for the lack of minority leadership to go unchallenged.

Ethnic diversity was generally seen as absent in institutional policy, as well as curriculum, a situation which Martin and Kipling (2006) saw as akin to institutionalized racism. Racism is rarely addressed at a systemic level in institutions and educational programs. Martin and Kipling noted:

Because “racism” was invisible, one might claim that it does not exist. Information about anti-racist policies was somewhat difficult to locate as it was embedded in policies and procedures about respectful learning environments and prevention of harassment. Information about anti-racist policies and inclusive learning environments was not included in course syllabi, implying that racism does not occur in schools of nursing and

inclusive learning environments are a taken-for-granted feature on the part of nursing faculty members. (2006, p. 694)

Paterson, Osborne and Gregory (2004) looked specifically at the impact of clinical education experiences on students from diverse backgrounds. They described competing discourses of homogeneity and difference in the experiences of students. Despite the stated overarching commitment of nursing to equality and homogeneity, the students studied reported that “difference can be a problem” (p.5). They indicated that ...clinical nursing education is socially organized in such a way that the stated intention of the teachers and the curriculum to foster an appreciation of cultural diversity is in fact compromised and often contradicted because it is based on ruling relations that often preclude difference. (pp. 5-6.)

In Paterson’s (1998) view, such ruling relations arose because clinical educators have been socialized and work in a health care context that values activism, independence, individualization and assertiveness. Nursing students who do not demonstrate such qualities may be viewed as “problematic” (Paterson, Osborne, & Gregory, 2004, p. 10).

The following section of the chapter addresses the literature specific to the experiences of Aboriginal nursing students in Canada.

### ***The Experiences of Canadian Aboriginal Nursing Students***

There was no intent in this study to equate directly the experiences of Canadian Aboriginal students with immigrants and visible minorities. There are some obvious differences. Many Aboriginal students are members of First Nations groups that have treaty relationships with the federal government. These relationships impact education. The policy solutions addressing participation for First Nations students in accessing nursing education require involvement of provincial, federal and First Nations government. The focus in this literature review was not on the policy solutions, but on the experiences of Aboriginal students and the leaders who have acted to increase their success in nursing education.

There were also some differences between the experiences of Aboriginal and immigrant students at a personal level. Kymlicka (1995) noted that immigrants tended to

experience racism based on the expectation that they should return from whence they came. Aboriginal peoples' experiences of racism tended to relate to a rejection of their status as distinct peoples with their own customs and communities.

The literature however, did demonstrate some common themes in the experiences of Aboriginal students, immigrants and visible minorities, related to racism, eurocentricity, and lack of knowledge and respect for views of health and learning.

Martin and Kipling (2006) observed that, like other minority students, Aboriginal students reported frequent experiences with racism:

Visible and non-visible Aboriginal nursing students observed and detected racism from individuals, groups, and processes within the schools, hospitals, and community placements. In the learning environment, several Non-Aboriginal individuals exhibited racist attitudes and behaviors that were hurtful. In the majority of instances, unwitting insensitivity and/or lack of knowledge about the influences of colonialism and neo-colonialism were demonstrated as Non-Aboriginal peoples openly expressed viewpoints that Aboriginal peoples were all the same and had numerous resources available to them. Aboriginal nursing students who perceived degrading and/or disrespectful treatment from nurse educators described how these experiences “further added fuel to the fire” of how Aboriginal peoples have historically been treated. (p. 693)

The literature showed that racism and prejudice were experiences common to both minority students and minority nurses alike.

The eurocentricity of nursing education was frequently noted as a barrier for minority students, particularly Aboriginal students (Gregory, 2002). Martin and Kipling (2006) found in their study of Aboriginal students' experience that nursing curricula were often developed devoid of the context of Aboriginal peoples. Aboriginal ways of knowing and views of health were often at odds with Western approaches to education and health.

An attempt to discuss Aboriginal epistemology and views of health must proceed with care. While such discussion is intended to create awareness of potential areas of difference between Aboriginal traditions and current practices in health and education, one must tread carefully in doing so because of the risk of creating an essentialized laundry list of cultural practices that can then be arbitrarily attributed to Aboriginal students. The discussion that follows points to some potential areas of conflict between

traditional Aboriginal approaches to education and health and the experiences of Aboriginal students in eurocentric nursing programs which do not attempt to understand and incorporate these approaches.

Central to traditional Aboriginal ways of knowing is the concept of spirituality. Doige (2003) described Aboriginal spirituality as the “immaterial aspect of one’s personhood that connects with *otherness*, including for some a life force or immanence, especially the Creator, or God” (p. 144). Traditional Aboriginal epistemology maintained that learning without connection to a spiritual core is simply superficial knowledge of skills and facts. Aboriginal epistemology represented learning as linked directly with morals and values, and as a result, making connections to life experiences in relationships and nature (Doige, 2003). Learning could not be separated from spirituality, relationships and connectedness. All education therefore must have as its goal learning how to live a life of utmost spiritual quality (Doige, 2003).

Perhaps the word in the English language that best, though inadequately, summarizes this discussion is *holism*. Aboriginal ways of knowing traditionally do not leave information compartmentalized, but search for connections and meaning. These connections are not expressions of an objectified system such as religion, but were “expressions of an individual’s spirituality in relationship” (Doige, 2003, p. 147). Reality is, to the traditional Aboriginal mind, subjective, personal, and the direct result of processes, consciously experienced (Couture, 1991).

The inadequacy of the word *holism* in representing Aboriginal epistemology emphasizes another aspect of cultural difference—that of language. Language serves as one of the institutions of a culture that assist in its reproduction (Marshall, 1998). Language serves an important function in Aboriginal culture as Aboriginal culture is passed on to future generations through the *oral tradition*.

Battiste argued before the Royal Commission on Aboriginal Peoples with respect to the ways in which Aboriginal language differs from English and French, using the Mi’kmaq language as an example. The Mi’kmaq language uses nouns and verbs differently than does English or French. The language is based on relationships, demonstrated by a reliance on verbs describing action, rather than nouns, focusing on

individuals. Aboriginal languages are made up of relationships, rather than fixed objects. It is the relationship of an object or individual with its surroundings, rather than the object itself, that is significant (INAC, 1996). Clearly, differences in language structure and usage between Aboriginal languages and European languages have the potential to cause challenges to some Aboriginal students' understanding.

A culture based on oral tradition requires personal contact. Much of the traditional knowledge was passed down in ceremonies such as sweat lodges, naming ceremonies and talking circles (INAC, 1996). Community members, extended family and Elders played strategic roles. This stands in stark contrast to the nature of learning in eurocentric education, where the teacher is the central figure in the knowledge transaction (Harris, 2002).

The separation of learning from day-to-day experience is embodied in the role of today's places of learning, including universities. Considine (2006) described the university as a "knowledge-based binary for dividing the known from the unknown" (p. 257). The university was viewed as being differentiated traditionally from other institutions in society by its distinct role as creator of knowledge, separate from the commercial application of this knowledge. This distinction required that university faculty be autonomous agents.

Harris (2002) described the university as the chief societal mechanism for reproduction of the Western cultural image. Harris saw the Western cultural image as a world view based on positivistic scientific principles:

The western mode ...is based on principles of objectivity (that the observer must divorce himself or herself from the observed), empiricism (if it is real it can be measured), and reductionism (the whole can be known from an examination of its parts). (Harris, 2002, p. 188)

Science serves as a model for Western intellectual endeavors far beyond the scientific domain. The scientific method is the epistemological foundation for both the education and health care systems in Western society (Harris, 2002; Darbyshire, 1999). As noted in the preceding discussions of Aboriginal views of health and learning, Aboriginal people have traditionally rejected this view of objectivity, empiricism, and reductionism. Harris (2002) stated of the Aboriginal view of objectivity: "...every aspect

of Creation is continuously interacting; the observer is interacting with the observed and, therefore, logically cannot be divorced from it” (Harris, 2002). Of empiricism, she indicated “The principle of empiricism is obviously erroneous because some of the most important aspects of creation cannot be weighed and measured: the Great Spirit, the knowledge obtained from dreams, love of family and community, and so on” (Harris, 2002). Reductionism was dismissed as failing to recognize the synergy of an object or phenomenon when reducing it to its constituent parts (Harris, 2002). The concepts of spirituality, relationships and language usage were therefore fundamental to the understanding of Aboriginal epistemology. They also played a large role in the understanding of the traditional approach to health in Aboriginal cultures.

Concepts of spirituality, holism, harmony, respect, and balance were significant to an understanding of the Aboriginal view of health. As with learning, Aboriginal people do not view health in the compartmentalized manner of the North American medical model. Holism requires that the person be viewed as an entity integral to the surrounding relationships and nature. Wasekeesikaw (2006) used the term *miyupimaatissium* or “living alive well” to describe the holistic, interdependent relationship Aboriginal people have with nature and with attending to spiritual strength. It is cyclical in nature. *Miyupimaatissium* assumed eating well, which assumed a good hunt. This required that the male hunter had the strength to enter the hunt, and that the woman had the wisdom and skill to prepare the food. It required that the Earth provided the animal for the hunt and that the animal gave its spirit to the hunter at the end of the hunt.

Living alive well also focused on the importance of harmony with the Earth and with each other. This required an approach very different from that of North American intellectual culture, as exemplified by the following statement outlining the Aboriginal view of the role of the individual: “Individual beings are designed to help one another in order to fulfill the requirements of wholeness, balance and harmony, interconnection, and interrelationality. Therefore, to practice vanity as a lifestyle can be destructive” (Atleo, 2004, p. 35). This statement spoke to the unique view of the individual as part of the collective, a very different concept from the Western cult of the individual.



Balance and respect were important holistic aspects of Aboriginal health. Lowe and Struthers (2001) wrote that “silence, male, female, non-compartmentalization, flowing in harmony and pursuing peace are components of the characteristic of balance” (p. 279). Respect was a central concept in Aboriginal views of health (Lowe & Struthers, 2001). Respect included “characteristics of relationship, honor, identity, and strength... presence and compassion” (Lowe & Struthers, 2001, p. 279).

The Aboriginal tradition of storytelling was viewed as a way of transmitting knowledge from generation to generation while honoring the need for harmony and balance (Harris, 2002). Storytelling provided opportunities for indirect guidance without confrontation and disruption of harmony. It provided a way of teaching without directing. The Aboriginal values of spirituality, holism, harmony, respect, and balance, passed on through a tradition of ceremonies and storytelling, stand in stark contrast to Western views of health and healing.

Berry (2008) observed that Aboriginal ways of knowing and views of health have often butted up against the scientific method and the medical model, where both are based on compartmentalization and pathology. The contradictions between the two world views have set up Aboriginal students in nursing and other professions for confusion and lack of familiarity with the taken-for-granted assumptions underlying eurocentric approaches to education and health. This, coupled with overt or covert racism on the part of faculty and administration, creates challenging learning environments for Aboriginal students in the health professions.

In addition to these basic underlying philosophical differences in approach, Aboriginal students in nursing often faced practical challenges as well. Inadequate educational preparation was seen as a significant systemic barrier for Aboriginal students in Canada. Post secondary education of any kind has not been the norm for Canadian Aboriginal people. Gregory (2002) indicated that, at current rates of educational participation, 70% of Aboriginal children born in 2002 are destined never to complete high school. The high school completion rate of Aboriginal Canadians (15 and older) in 2006 was 56.3 per cent overall, compared to the non-Aboriginal rate of 76.9 per cent (Community Foundations of Canada, 2009). Band-based education systems have been

unable to provide sufficient levels of basic skill development, and have often not offered the prerequisite courses for admission to nursing and other health professional programs. First Nations-managed schools have often not had access to accredited teachers, especially in the area of mathematics and science (Gregory, 2002).

Lack of faculty role models has been seen as a significant barrier for Aboriginal nursing students. Gregory (2007) reported only 31 Aboriginal faculty members in 59 Canadian baccalaureate nursing education programs. He advocated positive, or *affirmative actions*, to insure participation of Aboriginal students in nursing education. Such actions involved designation of a portion of seats in each Canadian nursing program for Aboriginal students. However, similar affirmative actions in nursing education have met with impediments in the United States:

In recent years, United States courts have handed down a series of contradictory judgments about affirmative action policies, which consider race as one of several factors during the admissions process. Some of these decisions have curtailed affirmative action in California, Washington, Texas and other states; others have affirmed that diverse classrooms are crucial to the education system and have upheld school policies. ...

Many legal experts believe that the Supreme Court will reexamine affirmative action in the near future in order to resolve the conflicting decisions by lower circuit courts. (Nursing School Education Resource Center, n.d., para 8)

This review of the literature demonstrated that immigrant, visible minority and Aboriginal nurses were not found in numbers reflective of their population groups in the community, and that they reported experiences of personal and systemic barriers in joining the profession, and in practice. While professional groups indicated a desire to increase the number of Aboriginal, visible minority and immigrant nurses in their memberships, progress toward this goal has been slow. This study addressed the mechanisms by which professions, either intentionally or unintentionally, limited the participation of underrepresented groups. This process is called *professional closure*, and is discussed elsewhere in the chapter.

### ***Conceptual Approaches to Difference in Nursing: Cultural Approaches***

The nursing literature reviewed generally employed three approaches to culture: *cultural awareness*, a functionalist “laundry list” approach to learning about cultural practices, ceremonies and institutions; the *cultural competence* approach, an interpretivist approach aimed at cultural sensitivity; and *cultural safety*, a critical approach to culture which incorporated some understandings of colonialism and power, generally from the perspective of the Maori of New Zealand, where the concept originated (Berry, 2008; Johnstone & Kanitsaki, 2007; Smye & Brown, 2002).

**Cultural awareness approaches.** A *cultural awareness* approach to difference employed the “cookbook” approach (Gustafson, 2005). With this approach, “people are lumped together on the basis of a shared language or heritage of a language, a shared historical experience, or shared cultural traditions and practices” (p. 7). Gustafson described a commonly used first year nursing textbook which compared health-related beliefs and characteristics of four groups in a matrix. Groups were arbitrarily defined on the basis of ethnicity. Gustafson considered such approaches to be reductionist, ignoring the many differences among group members such as gender, sexuality, religion, class, and economic status (Gustafson, 2005). Campesino (2006) echoed this concern, citing issues with the essentialist approach of attributing particular characteristics as inherent to all members of a group of people.

Reliance on categories and checklists of cultural and ethnic group characteristics can reinforce rather than ameliorate stereotypes and make it more difficult to recognize the heterogeneity that exists within groups. Cultural diversity under these conditions may become a naïve celebration of interesting cultural artifacts and practices of people, without addressing underlying social conditions of oppression that may be operating. (Campesino, 2006, p. 300)

Culley (2006), writing about culturalist approaches to health care clients, discussed the limitations of what she refers to as the “factfile” or “checklist” approach:

As a practice, the use of cultural checklists can result in bypassing the need to engage with the knowledge that underpins the experience and personal choices of [healthcare system] users. It can limit professional interventions and make it more difficult for professionals to support the choices of users. It gives rise to professional anxieties about ‘getting it right’ and channels practice into safe and unimaginative areas. (p 150)

**Cultural competence approaches.** The study of culture and nursing in the last three decades was directly influenced by the work of Madeline Leininger, a nurse anthropologist who articulated the Transcultural Nursing (TCN) approach reflected in most of the literature and virtually all nursing textbooks to date. Leininger defined transcultural nursing as “the humanistic and scientific study of all people from different cultures in the world with thought to the ways the nurse can assist people with their daily health and living needs” (Leininger, 2002, p.8).

The principal concept of TCN is *cultural competence*. Gustafson (2005) described cultural competence as:

...a quantifiable set of human attitudes and communication and practice skills that enables the nurse to work effectively within the context of individuals and family from diverse backgrounds. A culturally competent nurse performs a nursing assessment, using her or his knowledge and communication skills to identify the client’s cultural similarities and differences, and to establish mutual goals for care. If the nurse finds that her or his cultural beliefs conflict with those of the client or family, she or he may integrate the client’s wishes into the plan of care. If that is not possible because of possible harm to the patient, the nurse helps the client adopt new patterns of behavior. If the nurse finds that her or his individual biases get in the way of implementing culturally sensitive practices, she or he is encouraged to participate in educational programming and consciousness raising to remediate deficits in culturally specific knowledge, skills and attitudes. Thus culture care is located within the space of the nurse-client relationship. (pp. 2-3)

The language of TCN emphasized adaptation and remediation at the individual level. Increasingly, nurse scholars have registered criticism and concern with the limitations of the predominant approaches of nursing to culture, and TCN in particular (Campesino, 2006; Culley, 1996; Duffy, 2002; Gustafson, 2005; Mulholland, 1995; Swendson & Windsor, 1996). Giddings (2005b) summarized her concerns about TCN, saying “Nurses are assumed to form a politically neutral and homogenous group; their client populations are diverse with culturally specific needs” (p. 304). She goes on to say “The ideological assumptions and associated discriminatory practices captured in the construction of the ‘White good nurse’ are so integrated within the routines of everyday mainstream nursing that they are normalized” (p. 310).

In addition to assumptions of professional neutrality and homogeneity, The TCN approach focused attention at the level of the individual. Gustafson's critique of the TCN cultural competence approach was that it is deeply rooted in liberal ideology that "...values and promotes individual responsibility for health and well-being, informed choice, self-awareness, tolerance, and the ethic of care" (2005, p. 3). Liberal ideology stressed the individual and individual rights, freedom and autonomy, and assumed a society which is, at its foundation, equitable and egalitarian. It assumed that one's position in society is earned through personal achievement and effort, and was not related to group membership. Gustafson's critique saw this individualistic approach as one that failed to explore the power relationships within and beyond the primacy of the individual nurse-client relationship. The relationship was viewed as one of individuals, rather than one embedded in societal, institutional and structural processes (Gustafson, 2005).

...I assert that TCN operates from a liberal standpoint that focuses attention on a broadly based, but narrowly applied, concept of culture. The knowledge, beliefs, and values that underpin TCN Theory organize the goal of providing culturally competent care and the process or strategies used to achieve that outcome. These goals and strategies are embedded in, and mediated by, the hierarchically ranked social order both within and beyond nursing. The outcome is a broadly based, dynamically interconnected and depoliticized project of knowledge production that reinscribes the dominant liberal approach to social and human differences. (Gustafson, 2005, p.3)

Camposino (2006) described similar concerns with the limitations on nursing imposed by the humanistic aspects of the liberal tradition:

A humanist perspective emphasizes notions of equality and individual freedom, and operates on an assumption of human commonality among people. An ethic of caring and respect for individual clients' values are integral to quality health care. A potentially problematic aspect of a humanistic perspective arises when differences between the nurse and client related to racial, ethnic, or class categories are conceptualized simply as a function of varying cultural group norms, values, and expectations, rather than reflections of social categories that are imbued with power differentials. It may be easy to overlook how social hierarchies influence nurse-client interactions when a caring ethic assumes that all clients should be, and therefore will be, treated the same. The preponderance of evidence within health disparities research indicates that such notions of equality are ideals, rather than realities. (p. 299)

The underlying assumption of TCN implied that we all start from a position of sameness (Gustafson, 2005). It failed to acknowledge the role of history, geography, or colonialism, and implied whiteness as a politically neutral identity position (Blackford, 2003; Gustafson, 2005). In effect, "...whiteness, as a socially constructed dominant racial grouping with particular privileges, escapes scrutiny and becomes the invisible defacto norm" (Campesino, 2006, p. 302).

Cautioning this view of sameness, Gustafson (2005) states:

Appealing to a universal subjectivity reasserts the view that we are all *just people* negotiating interpersonal relationships while simultaneously obscuring the power of the very social processes used to organize those engagements. The liberal discourse of individualism in TCN Theory renders less visible, and, therefore, less eligible for discussion, the derivative social practices that perpetuate racism, sexism, and other systemic oppressions. (p. 6)

Culley (2006) echoed these criticisms:

Transculturalism rests on liberal assumptions that stress the individual and individual rights and freedoms, responsibilities and actions. There are many critics of this approach, who highlight a failure to theorize power relationships; a lack of awareness of the social context and discourses that shape social identities and representations; a depoliticisation of healthcare; a privileging of individualism, and a naive optimism and rationalism inherent in the educative project arising from the underlying assumptions of transcultural theory. Policy discourse based on transculturalism locates responsibility for appropriate care within the practitioner-client relationship, and assumes a pluralism in which group identities are different from, but equal to, each other. (p. 146)

According to Browne (2001), the liberal contribution to nursing science limited its view, focusing on individualism, egalitarianism, freedom, tolerance, neutrality, and free market economy, as resulting in "maneuvering within injustice" (p. 123). Cultural insensitivity was viewed as a problem of the individual, to be treated by "re-education" (Culley, 2006). This echoed the criticism of the individual approach to the "problem" of diversity identified by Paterson, Osborne and Gregory (2004) in the opening segment of this section on minority nursing students.

Critics saw the cultural competence approaches of health practitioners as based in the belief that cultural differences were the source of health problems (Culley, 2006).

Static, rigid cultural practices were “alien” and members of the cultural group are seen as “deficient,” according to Culley:

The impact on health-care has been to perpetuate a deficit approach to cultural difference; to engender negative stereotypes of minority ethnic clients; to render ‘white’ ethnicity invisible; to fail to see the significance of racism and, ultimately, to encourage a limited form of professional practice. (p. 147)

Kirkham and Anderson (2002) described the unevenness of the application of cultural concepts in nursing. They described the focus on practices that are considered exotic, interesting, or different as a holdover from colonialist and racist constructs of “strangeness.” Of the power differential in the application of cultural concepts in nursing, Gustafson (2005) wrote:

Those of us in positions of power have the luxury of expressing tolerance and sensitivity for non-dominant beliefs and practices. Those of us who are marginalized are expected to be satisfied with being tolerated or having our diversity celebrated rather than being able to expect fair treatment as professionals and equitable access to healthcare as clients. (p.12)

She went on to say:

To be effective, strategies for inclusivity must examine how and under what conditions inclusion and exclusion occur. This means making explicit the centrality of the dominant, liberal approach to healthcare in the construction of nursing knowledge and institutional practices. Specifically, creating space for the expression of difference demands that the nurse-client relationship is located within the larger institutional and systemic contexts that shape and constrain social practices, identities, and identifications. (p.13)

Advocating for a critical multicultural approach to difference in nursing, Gustafson supported an approach that focused beyond the individual and individual relationships, one that inherently looked at change—at challenging the status quo. The critical cultural perspective situated “social relationships within a dynamic social hierarchy, at a given point in time and space” (Gustafson, 2005, p. 3) and looked at

difference and change in this dynamic setting. It explored the structural systems of power such as racism, classism, ethnocentrism and paternalism that are entrenched in society, and invisible to those in positions of power (Campesino, 2006). Campesino saw the nursing literature as largely silent on the structural systems of power that exist, and how they impact the nature of the health care system, the profession, and the care it provides.

Contrary to many of the writers addressing issues of inclusion in nursing, Giddings (2005b) criticized the belief that the solution to the cultural disconnect between nurses and patients will be solved by recruiting minorities into nursing. Speaking about her research with Maori nurses in New Zealand, she stated:

The unjust expectation that marginalized groups provide the solution for problems caused by nursing's discriminatory practices was apparent...Maori nurses were expected to be the cultural safety experts, students who belonged to "ethnic groups" were responsible for the visibility of their specific health issues...The popular solution to the "minority nurse problem" ...to increase the intake of racial minority people into nursing, teaching and research...without first establishing strategies to counter institutionalized racism reflects this 'let them fix it' approach. (p.310)

In Giddings' view, expecting the recruitment of minority groups to solve their "problems," only served to essentialize their expected skill set and continued to make diversity about "them", rather than about how society defined and treated difference.

This critical view of the cultural competence literature in nursing emphasized the importance of finding a body of literature to support this study that incorporated structural inequities and concepts of power in its approaches. This body of literature was found in the discussion of cultural safety.

**Cultural safety approaches.** The concept of cultural "safety" was derived from the idea of safety as a nursing standard that must be met in practice (Smye & Browne, 2002). Nurses cannot ignore the safety of their clients. By making culture a *safety* issue, the concept of cultural safety attempted to make attending to the power structures in health care a nursing imperative. Cultural safety addressed the awareness of power and history in the relationship between nurses and clients. Giddings (2005b) wrote of cultural safety:



Rather than assuming the homogeneity of nurses, cultural safety promotes their cultural self-awareness and places racism at the center of its processes. Nurses are expected to give culturally safe care as determined by that person or family. (p. 304)

There is disagreement in the nursing literature with respect to the power of cultural safety approaches. Culley (2006) asserted that the concept of cultural safety had the potential to address the limitations of transcultural approaches, but was limited by its tendency to embeddedness at the level of the *individual*:

While the concept of cultural safety usefully prompts us to consider how health policy discourses have been shaped in relation to political, social, and economic structures, there are those who argue that cultural safety is still ultimately appealing to a personal attitudinal change as the main way to promote culturally safe practice. (p. 147)

Authors such as Smye and Browne (2002) disagreed with this characterization of cultural safety as an individualistic approach. They quoted the developer of the cultural safety concept, Ramsden, a Maori nurse leader, in saying that cultural safety focused on “life chances” such as access to health services education and proper housing, as opposed to “lifestyles.” According to Smye and Brown (2002) “Cultural safety is, therefore, not about ‘cultural practices’; rather it involves the recognition of social, economic, and political position of certain groups within society” (p. 46).

While there has been controversy in the nursing literature with respect to the suitability of cultural safety as a critical concept, it is important to note that it has gained some significant support in recent months. In 2009 a joint document produced by the Aboriginal Nurses Association of Canada (ANAC), the Canadian Association of Schools of Nursing (CASN) and the Canadian Nurses Association (CNA) advocated the contemporization of the concept of culture used in nursing, and advocated an understanding and demonstration of cultural safety as a core competency in Canadian nursing education curriculum (ANAC/CASN/CNA, 2009).

### ***Race, Ethnicity and Difference in Nursing***

Race and racism are topics of controversy in nursing and nursing research literature (Porter, 2004; Porter & Barbee, 2005). Kirkham and Anderson (2002) noted that difference in nursing was often equated with concepts of race, ethnicity, and culture.

These concepts were often used interchangeably and were used to connote inferiority. These authors advocated a critical approach to difference, which accepted that race is not a biological concept, but a social one. A critical approach views the concepts of difference as social constructions.

Originally carrying a meaning that referred to biological origin and physical appearance, race is now understood to be a social construction manipulated to define, structure, and organize relations between dominant and subordinate groups. Although any biological component of race has been disproved, people continue to be grouped according to what are considered physical race attributes; as a result, race persists as a central aspect of everyday life. As a constitutive element of our common sense, race is a key component of our taken-for-granted reference schema through which we get on in the world. (Kirkham & Anderson, 2002, p.4)

This view of race in the nursing literature corresponded with that described by McMahon (2007) in the education literature. McMahon viewed the meanings attached to race as relational, defined in conjunction with and in opposition to other groups, and changing over time as their relations to society change. The process by which biological characteristics were given social significance was referenced as *racialization* (Johnson et al., 2004; Kirkham & Anderson, 2002; Kirkham, 2003). Culley (2006) described this process as “the way in which ideas about race are mapped on to particular groups or populations in specific contexts” (p.145). While the *concept* of race was not an actuality, the literature showed clearly that the *experience* of racism was.

Racism was viewed by many authors as intersecting with other issues such as sexism and classism to create interlocking analytical categories in looking at societal inequities (Kirkham & Anderson, 2002). As discussed previously in the chapter, it has been difficult for the nursing profession to see racism in its practice. Culley (2006) described nursing as constructing itself as a caring, color-blind, class-blind profession. Nurses were all “just folks,” they treated everyone the same. She added, “There is a denial that nursing is embedded in unequal relations of power that structure interactions between nurses and their patients (and also interactions among nurses)” (Culley, 2006, p. 145). Bonilla-Silva (2006) identified the current racial consciousness in nursing as “color blind racism”, whereby direct discourse on race is avoided, and current racial privilege is

safeguarded. Bonilla-Silva identified the effect of color blind racism as “otherizing softly” and referred to it as “smiling face discrimination” (p.3).

The inability of nursing as a profession to see itself as perpetuating racist practices allowed such practices to continue. Giddings (2005b) noted “It is the hidden nature of discrimination within the nursing profession that maintains the privilege of those who fit the ideal of the “White good nurse” and the marginalization of those who do not” (p. 311). The view that nursing is neutral, color blind, and class blind corresponded with Shields’ view of the teaching profession. Shields (2004b) writing in the education literature, reminded us that “...being color-blind is a hegemonic practice that only white people have the luxury of believing” (p.118). Shields maintained that such views result in *pathologies of silence*. Pathologies of silence occur when professionals are uncomfortable with difference, and lack the skill to acknowledge and celebrate differences in ways that leave behind practices of labeling and essentializing single characteristics. Differences, if acknowledged at all, are pathologized (Shields, 2004b). Racism can be seen as a form of Othering, which is discussed in the next section of the chapter.

### ***Diversity: Related Concepts in the Nursing Literature***

The nursing literature includes two approaches which describe the way in which difference has been pathologized: marginalization and Othering.

**Marginalization.** Vasas (2005) saw marginalization in parallel with social exclusion, which she defined as “...norms and processes that prevent certain groups from equal and effective participation in the social, economic, cultural, and political life of societies” (p.195). She believed that marginalization exists as a concept, a process and an experience. Much of the nursing literature addressing marginalization looked not at the *process* of marginalization, but at the *experience* of marginalization (Hall et al.; Vasas, 2005). Vasas (2005) called for more attention to the process of marginalization, as a way of enabling nursing as a profession to understand how it contributes to the marginalization of certain groups.

Marginalization occurs in relation to the margin (Murphy, 1999; Vasas, 2005) Margins are defined in relation to the Center, producing a binary Center-Other. The

Center includes the powerful mainstream. Vasas described the marginalized as invisible to the Centers.

...marginalized peoples are invisible to those at the Center because they are not present in their immediate environments...Therefore, their needs and voices are often not heard by those in the Center....privilege nurtures blindness toward those without the same privilege. (p.196)

The process of marginalization results in specific groups having limited access to social power, being prohibited from resources, and subjected to differential treatment (Vasos, 2005).

**Othering.** Defining marginalization in relation to Center and Other, the concept of Othering appears. Othering as a concept was discussed in the nursing literature, primarily in the fields of psychiatric and forensic nursing (MacCallum, 2002; Pernelij-Taylor, 2005).

Othering is the resultant process of distinguishing between the Center and Other, between the dominant society and those that are different from it (Hall, 1994). Kirkham & Anderson (2002) defined Othering as "... an act of representation by which identity is assigned, human existence is categorized, people are characterized according to certain criteria (such as worldview or similar anthropological construct) and experiences are homogenized" (p.6). Othering served to magnify difference and reinforce positions of domination and subordination (Johnson et al., 2004).

Canales (2000) made a significant contribution to the nursing profession's understanding of difference when she defined Othering as the process of engaging with those perceived as different. Others were marked or named in relation to the roles they play (Canales, 2000). How the Other was perceived had consequences for how the Other was defined. She viewed Othering not only at the individual level; she saw it as a process operating on many levels. Othering

...identifies how inclusionary and exclusionary practices operate at multiple levels, within individuals, families, communities, and society as a whole. Nurses cannot focus solely on the individual client or student; instead, they must be engaged with and committed toward effecting change at multiple levels and within multiple groups" (Canales, 2000, p.17).

Nurses were challenged to understand that the results of Othering, while occurring at the level of the individual, stem from power and structural inequities at a societal level, and to view, as part of their role, activities that lead to social change (Canales, 2000; Kirkham & Anderson, 2002).

The conceptual model of Othering developed by Canales (2000) involved two aspects: Exclusionary and Inclusionary Othering. Exclusionary Othering used “the power within relationships for domination and subordination. The consequences for persons who experience this form of Othering are often alienation, marginalization, decreased opportunities, internalized oppression, and exclusion” (2000, p.19). Studies of difference almost exclusively focused on negative views of Othering. Most nursing literature addressing Othering did so from this perspective. Exclusionary Othering was often influenced by the visibility of the Otherness. Othering was often created around race and ethnicity. Stigmatizing attributes obvious to others included skin color, language, physical abilities, gender, or age.

A major theme in the work of Culley (2006) identified the failure of nursing and health professional literature to address the creation of Others, and the failure to address ‘white’ as neutral:

For many in nursing the ‘ethnic’ is still the ‘Other’, that is it is not perceived as ethnicity at all. The silence on the construction of ‘white’ ethnicities marks a major omission in health research. The need to deconstruct the category ‘white’ is especially important in understanding the potential health experiences of many less visible minorities. (p.147)

Addressing the challenges created in nursing and health care by Exclusionary Othering, Canales noted:

I propose that the consequences of Exclusionary Othering within health care delivery often result from the failure of nurses to take the role of those they perceive as different from themselves. This includes colleagues, students and clients. Failed role-taking efforts may be in the form of inaccurate role-taking, such as misinterpreting the actions of another; eclipsed role-taking, such as listening to only those perspectives that are familiar or consistent with one’s own thinking; or resistance to role taking, such as not attempting to listen to voices other than one’s own. Often the consequences of failed role taking, regardless of its form, directs their actions according to stereotypes and myths rather than to an understanding of the perspective of the Other. (2000, p. 23)

The model of Othering articulated by Canales included another aspect of Othering in addition to Exclusionary Othering. Inclusionary Othering, by contrast, used the power within relationships for transformation and coalition building, with resultant consciousness raising, sense of community, shared power, and inclusion (Canales, 2000; Perternelji-Taylor, 2005). Inclusionary Othering necessitated role taking as outlined in the previous quotation—coming to view the world from the perspective of the Other. Taking on the role of Other allowed one to “...begin to understand the meaning of the other’s world” (Canales, 2000, p. 19). Role-taking was akin to empathy or insight. Canales saw role taking as central to the creation of transformative relationships that lead to empowerment.

Canales (2000) advocated reconceptualizing difference, not as a tool of segregation used to exercise power, but as a tool of creativity for exploration, critique and empowerment.

The parallels between the use of Inclusionary Othering in the nursing literature and the Communities of Difference perspective in the education literature were obvious. Both conceptual approaches drew on positive, inclusive, appreciative perspectives. The conceptualizations of difference as Othering and marginalization were important in understanding the experiences of the stories told by the leaders in this study, and for that reason, were included here.

### **Review of the Literature: Professional Closure**

In order to understand the need for leadership to increase diversity within nursing, it was important to situate nursing within the context of the professions, and the health professions in particular. This section of the chapter reviews the literature regarding professions and their approach to diversity.

An investigation into diversity and the professions unearthed the body of literature commonly referred to as the sociology of the professions. This field of study grew out of discussion about professions by scholars in the United States and the United Kingdom. Much of the discussion occurred in the late 1970s through the 1990s. The literature with respect to the sociology of the professions identified professions as occupational groups with specialized skills, advanced education, state recognition, a commitment to altruism,

self regulation including professional control of education and admission to practice, and positions of societal privilege (Hugman, 1991; Murphy, 1984; Torstendahl & Burrage, 1990; Witz, 1992). This social privilege and its concomitant power and elitism were termed by sociologists *professional closure*.

Professional closure is an example of what Weber referred to as *social closure*, the “process by which social collectivities seek to maximize rewards by restricting access to resources and opportunities to a limited circle of eligibles” (Parkin, 1979, p.44). Murphy described Weberian social closure in more pejorative terms: “... the process of subordination where one group monopolizes the advantages by closing off opportunities to another group of outsiders beneath it that it defines as inferior and ineligible”(2001, p.23). Marx’s theory of closure emphasized society class structure and professional place in relation to the class system (Baskerville-Morley, 2003).

Dressler described professional closure as

...active mobilization of power to enhance or preserve one’s place in the hierarchy. Enhancement or preservation may proceed by excluding certain classes of persons from competition for social rewards, or in the case of lower status persons or groups, it may proceed by attempts to usurp others’ prerogatives. (Dressler, 1994, p. 336)

These views were supported by the work of Parkin (1979), who developed Weber’s work further, delineating two aspects: exclusionary closure and usurpation. Exclusionary closure involved “...the exercise of power in a downward direction through a process of subordination in which one group secures its advantages by closing off the opportunities of another group beneath it...” (Murphy, 2001, p. 23). Parkin’s usurpatory exclusion involved the “... exercise of power in an upward direction in order to bite into advantages of higher groups...” (Murphy, 2001, p. 23). Exclusionary closure for professions occurred when the group was successful in limiting access to resources based on their control over their credentials, and the means to achieve these credentials. Professional closure referred to the maintenance of monopoly of a self-defined body of knowledge (Witz, 1992). Hugman (1991) saw professional closure extending beyond control over credentials and a scientific body of knowledge to include the concomitant skills that correlate with knowledge, gained through control of professional education programs,

and control over the performance of those skills. Parkin described closure as limiting access on the basis of credentials, race, religion, or language (Murphy, 2001).

Weber's views on professional closure were cited by Hugman:

...when we hear from all sides the demand for the introduction of regular curricula and special examinations, the reason behind it is, of course, not a suddenly awakened thirst for education but the desire for restricting the supply for these positions and their monopolization by the owners of educational certificates...(1991, p.84)

Thus professional closure was viewed as limiting the performance of professional roles to those accredited by the profession itself, and additionally, limiting the access of individuals to the educational and credentialed means of performing these roles.

The issue of limiting entry to professional practice was the subject of much study in medicine, but also extended to accountants, lawyers and engineers (Baskerville-Morley, 2003; Beck, 2004; Markowitz & Rosner, 1973; Walker & Shackleton, 1998). Measures that were traditionally been used to limit access to professions include restricted requirements around entrance, residency, and language (Baskerville-Morley, 2003; Walker & Shackleton, 1998).

### ***Professional Closure, Diversity and the Nursing***

Nursing was seen historically as a mechanism for rural and working class women to achieve respectable "middle class" status through completion of an apprenticeship education in hospital-based schools of nursing (McPherson, 1996). The literature demonstrated that the profession has been ambivalent about its working class connections, and the service and gendered nature of the work that it performed (Davies, 1996, McPherson, 1996). Nurses as a group have rejected the feminized view of their work and attempted to increase their status and through *professionalization*. By attempting to create a view of nursing work as the work of a profession, there was intent to move away from the ghettoization that occurs when an occupation is viewed as "women's work". By moving toward a professionalized view of nursing work, the nurturing, mothering role is minimized in favor of a view of nursing based on technical skill, scholarly knowledge, and research (Buresh & Gordon, 2006). The feminized "angels of mercy" view of nursing was referred to by Buresh and Gordon (2006) as the



*virtue script*, whereby nurses' contribution was based on feminine intuition and virtuous commitment, rather than professional knowledge and technical skill. Thus professionalization was a mechanism to reduce the gendered nature of nurses' work and thereby increase the status of nurses.

Hugman's discussion of professional closure addressed the historical process of professionalization of nursing, directed at "the state creation of an occupational monopoly grounded on a regulated form of training" (1991, p. 85). Closure was accomplished through monopoly control of credentialing, and control of training—including the location, duration, curriculum, and policies. Internal closure in the health professions was directed at the creation of subgroups (Hugman, 1991). In nursing, this resulted in stratification, with the formation of ancillary groups of sub-professional nursing assistant, licensed practice nurse and, in Britain, enrolled nurse positions.

In order to understand professional closure, it was necessary to understand the process of professionalization, or the development of professionalism. Keogh (1997) indicated that the timing and rate of nursing professionalization varied from country to country, occurring at differing rates over the last 50 years. Despite the variation in timelines, Keogh saw the profession move internationally from its apprenticeship and service orientation to take its place within the professions as a result of a number of initiatives: the development of the profession's own body of specialized knowledge through the advancement of nursing research; the movement of education into institutions of higher learning; control of professional policy and standards; the development of a nursing code of ethics; and a lifetime commitment to service.

Evetts (2003) identified two opposing aspects of the process of professionalism: professionalism as a *normative value system* and professionalism as *ideology*. As a normative value system, professionalism contributed positively to the role of the profession, reflecting the commitment of the profession to the social good. Professionalism as ideology focused more negatively on professionalism as a hegemonic belief system, and mechanism of social control (Evetts, 2003). Professionalism as a normative value system stressed the moral responsibility of the profession to its clients, and the community. Altruism and service were at the core of the professional value

system. In return for confidential, skilled interaction with clients, professionals were rewarded with authority, privilege, and status (Evetts, 2003).

Professionalism as an ideology gave way to power, privilege and monopoly aimed at elevated status and upward mobility. Evetts saw a tempering of this view in recent years, acknowledging a return to a normative value system approach:

One result of this return and re-appraisal is a more balanced assessment, however. Thus, in addition to protecting their own market position through controlling the licence to practise and protecting their elite positions, professionalism might also represent a distinctive form of decentralized occupational control which is important in civil society ... It has also been argued that the public interest and professional self-interest are not necessarily at opposite ends of a continuum and that the pursuit of self-interests may be compatible with advancing the public interest. Professionalism might also work to create and represent distinct professional values or moral obligations which restrain excessive competition and encourage co-operation. (2003, p.403)

The evolution of professionalism in nursing has been a focus for study by nurses and non nurses alike. Nurse authors generally saw professionalism in relation to its normative value interpretation. Stressing the covenant of the nurse-patient relationship and the ethical commitment to care of nursing as a profession as the focus of professionalization, they also view it as a means to increase the impact, effectiveness and authority of nursing.

Some nursing authors viewed the embracing of scientism by the nursing profession as an attempt to legitimize itself as a profession and an academic discipline. Adams and Bourgeault (2003) noted that the “ideology of science” was often used by professions in their attempts to legitimate their claims to expertise and elevate their professional status (p. 76). Locsin (2002) identified nursing’s intense preoccupation with predicting outcomes as one piece of evidence to support the preoccupation of the profession with science. Prediction and control are corollaries of the linear Western scientific method based on objectivity, empiricism and reductionism.

Nursing has attempted to capitalize on the scientific foundation of its practice by objectively defining and developing the science of caring and the process of care (Adams & Bourgeault, 2003). The move of nursing education into university settings and the

development of nursing research were viewed as mechanisms to increase the *scientific* credibility of the profession and increase its status (Berry, 2008). Other measures to advance the nursing profession included the development of nursing research and doctoral programs in nursing (Meleis & Im, 1999).

Prominent nurse author Philip Darbyshire (1999) noted that nursing attempted to distance itself from science because of its “perceived shortcomings and oppressive connotations” but that the profession nursing showed a simultaneous need for science as an “intellectual security blanket” (p. 124).

Much of the discussion of the need for professionalization and increasing the status of nursing related to nursing as a gendered (predominantly female) profession. Moves to increase professionalism, through such mechanisms as movement for credentialing from two-year hospital and college-based education programs to four-year baccalaureate education based in the university setting are seen by some authors as “an attempt to change nurses’ subordinate status in a male-dominated health care system.” (Rheume, 2003, p.547)

The drive by the nursing profession to increase its professionalization was viewed by Davies (1996) as a way of addressing the adjunct, supportive role nurses have traditionally had in the health care system. This stemmed from the gendered nature of nursing work.

Expertise derived from a formalized training based on science is central to a claim of professionalism. Whereas earlier commentators stress the essential benevolence of knowledge and skill in service of societal improvement, more critical scholarship has stressed the monopolistic character of professional knowledge, the creation of a mystique among the elite and the dependence and disabling of those who come to the profession in the capacity as client. Through the lens of masculinity we can expand further on this. Professional knowledge is gained by dint of a lengthy and heroic individual effort. This effort results in knowledge as a ‘possession’ of the autonomous individual. Knowledge and the associated skills and techniques are exercised in a visible, tangible, and agentic way; knowledge thus possessed is affirmed in use and can be neither depleted nor easily shared. The project of the bounded individual in controlling others is also reflected in the way the knowledge base of expertise is developed. The profession controls knowledge; it creates specializations, celebrating depth rather than breadth. Specialists with their ‘command’ of an area are more highly regarded than generalists. Locating the problem

and the solution in terms of knowledge thus ‘mastered’ affirms a sense of competence and order in both knowledge and practice; the work too is bounded and easy to define and defend. (pp. 669-670)

According to Meleis and Im (1999), this push for professionalization through increased knowledge and academic credentialing is motivated by the *marginalization* that nursing has experienced as a profession.

As nurses, we are not strangers to marginalization. We have been marginalized in the healthcare system, and we have been marginalized in our institutions as newcomers to academia. We have been marginalized because our research was not ‘hard’ enough, because we spent more time in teaching than other disciplines, because we do not bring the level of external funds that our colleagues in medicine and engineering bring, because we are women in male-dominated higher education institutions. (p.95)

The authors go on to point out that one of the ways nursing as a profession has responded to its marginalization is to marginalize others. “At some point in our history, we have marginalized diploma nurses, minority nurses, clinicians, educators, theorists, qualitative researchers, or empiricists” (Melis & Im, 1999, p. 95). The concept of marginalization was explored more fully earlier in the chapter.

The marginalization of other categories of nursing and care-giving personnel by registered nurses has been described as *segmentation* (Glazer, 1991). Segmentation “refers to the hierarchically ranked labor markets across which there is virtually no worker mobility; these markets differ from each other in wage levels and benefits, steadiness of employment, job autonomy, and other conditions of employment”(p. 352). Glazer viewed segmentation as occurring within nursing through two means: attempts by the nursing profession to professionalize itself by making a baccalaureate degree the entry point to the profession, and through prevention of replacement of registered nurses by licensed practical nurses and nurses’ aides. Glazer viewed registered nurses in this instance as being “between a rock and a hard place.” In attempting to increase their knowledge and skills to safely care for patients, and to increase their status in order to be seen as legitimate players in the health care team, registered nurses acted to limit access to education, licensing and legal definitions of scopes of practice of others. Glazer concluded

Segmentation may harm licensed practical nurses and nursing assistants who are disproportionately women of color and from poor households; segmentation freezes them into positions from which they cannot rise through on-the-job experience and provides a rationale for low wages, part-time work, and minimal job autonomy. (1991, p. 353)

Noted nurse historian Kathleen McPherson (1996) supported Glazer's view of registered nurses' segmentation of practical nurses and nurses' aides, placing registered nurses' resistance in the context of warding off health system implicit and explicit attempts to replace registered nurse jobs with lower paying ancillary roles. Despite her critical view of segmentation of nursing work, Glazer, an American sociologist, was not without sympathy for the position of nurses in their attempts to protect their professional roles. She stated that her views

...must not read as a condemnation of the actions of professional organizations of registered nurses. The various associations acted to professionalize registered nursing and to improve the care of the sick; some of their actions limited the opportunities of other women nursing personnel. Their actions occurred simultaneously with the regularization of training and licensing in other professions, which RNs took as a model, namely medicine, law and engineering. (Glazer, 1991, p.366)

Thus the literature revealed nursing as a profession striving to increase its influence, authority and contribution to health care. This was intended, in the eyes of the profession, to increase its effectiveness in advocating for its clients. However, the by-products of such an emphasis, either overtly or inadvertently, were increased professional closure. As we saw in Chapter One, the theoretical literature on professional exclusion was supported by studies showing that nursing in Euro-American countries such as Britain, Australia, the U.S., and Canada is a predominantly white middle class nursing workforce (Chua & Clegg, 1990; ICN, 2004). Page and Thomas (1994) discussed the professional closure of nursing along class and race lines, describing the creation of "white public space" by professions, including nursing, to sustain their privileged position in society. Their conceptualization related closely to Gustafson's (2005) concept of the "white, good nurse" in her discussion of culturalist approaches in nursing. Both concepts referred to the taken-for-granted nature of "white" approaches within the profession, and the exclusionary impact of such approaches for those in the minority.

This literature supported the stories of the leaders interviewed in this study with respect to the way in which nursing as a profession attempted to limit participation, and for that reason this discussion of the literature surrounding professional closure was included here.

### **Review of the Literature: Critical Leadership**

The literature dealing with the topic of leadership was seemingly endless. It spanned many disciplines, including business, psychology, education, and organizational studies. In an attempt to corral the discussion for the purposes of this study, most of the sources reviewed were found in the education literature, specifically the educational administration literature. In addition, the literature relating to leadership in nursing was reviewed.

The choice to use literature from the discipline of education arose primarily because it was the body of literature which was the most obvious source of *critical* approaches to leadership. The critical approaches of the leadership for social justice writers, and the critical theorists writing in the field offered approaches that resonated with my own epistemological and ontological approaches. The work of William Foster (1986; 1989) particularly attracted me, as it balanced the educative and ethical leadership approaches needed to effectively work with colleagues, with the critical, reflective, visionary and advocacy approaches necessary to look beyond the organizations and institutions when nurses work, and to relate the work of those nurses and institutions to the overall societal goal of achieving social justice. Foster's work was drawn from a sociological and moral theoretical background, which focused on leadership in community, and leadership from a moral sense. This offered a significant contrast to much of the leadership literature which originated in the field of psychology, which focused on and privileged leadership as a phenomenon of the individual. Foster's work in critical leadership formed the backbone of the conceptual approaches to leadership that guided this study.

In addition to Foster, Ryan's (2003; 2006a; 2006b) conceptualization of inclusive leadership, as well as the literature dealing with leadership for social justice previously noted, were significant in the formulation of the conceptual approaches for this study.

Literature addressing transformational and transformative leadership also resonated with me during the development of the study approaches. Leadership approaches that supported and enhanced critical leadership, including transformational, transformative, authentic, and servant leadership, plus leadership as vocation, were influential in conceptualizing the study, and are included in the review of the literature.

### ***Critical Approaches to Leadership***

This study was not focused on the traditional positional approaches to leadership—positions what Magliocca and Christakis (2001) referred to as the managerial, “just fix it” approaches to leadership. The research reviewed for this study primarily focused on leadership as a relational, ethical, social practice, and not as a positional phenomenon. It also addressed leadership for social transformation, aimed beyond the bounds of the organization. I referred to these approaches to leadership as *critical* leadership. For the purposes of this study, leadership was approached primarily from the meta-theoretical perspective of critical social theory. The critical social theory approach used was embedded in a radical humanist paradigm, as described by Burrell and Morgan in their 1985 classic article, *Sociological Paradigms and Organizational Analysis*. The radical humanist paradigm is

...committed to a view of society which emphasizes the importance of overthrowing or transcending the limitations of existing social arrangements...The major concern for theorists approaching the human predicament in these terms is with *release* from the constraints which existing social arrangements place upon human development. It is a brand of social theorizing designed to provide a critique of the *status quo*. (p.32)

Ideas from critical social theory, particularly ideological critique and critical reflection, were central to the study of leadership (Brown 2004). Critical reflection “...lays bare the historically and socially sedimented values at work in the construction of knowledge, social relations and material practices...it situates critique within a radical notion of interest and social transformation” (Giroux, 1983, pp.154-155).

Speaking with reference to education leadership, Brown (2006) advocated for a critical approach to leadership that aroused participants, engaging them in

...a quest to identify obstacles to their full humanity ...and ends in action to move against those obstacles. Preparing educational leaders to accept

this challenge necessitates both a close examination of personal beliefs coupled with a critical analysis of professional behavior. It requires the problematization of those taken-for-granted practices that we no longer notice, unless we are specifically asked to do so. (p.703)

Magliocca and Christakis (2001) saw critical leadership as being inherently about relationships, the purpose of which was to create the conditions whereby people could change their lives.

Perhaps the most prominent and eloquent advocate for a critical approach to leadership was William Foster, the “elder statesman of critical theory” in the field of educational administration (Anderson, 2004). His early works, informed by Marx, Braverman, Gramsci and Habermas, addressed the creation of societal institutions based on equity and social justice (Anderson, 2004). In his 1989 article *Toward a Critical Practice of Leadership*, Foster decried the rise of the managerial approaches to leadership described by Magliocca and Christakis:

In many ways the concept of leadership has been chewed up and swallowed down by the needs of modern managerial theory. The idea of leadership as a transforming practice, as an empowerment of followers, and as a vehicle for social change has been taken, adapted and co-opted by managerial writers so that now leadership appears as a way of improving organizations, not of transforming our world. What essentially has happened is that the language of leadership has been translated into the needs of the bureaucracy. (p.45)

The role of the leader, for Foster, was viewed in this way:

The meat of the administrator’s work is not the technical aspect of management; rather, it involves the establishment of a community and a culture within the organization and the development of an organization’s self-reflective ability to analyze its purpose and goals. (1986, p. 10)

Foster articulated a definition and criteria for leadership that separated it from the managerial approaches to leadership that he eschewed. By Foster’s definition, leadership must be critical, transformative, educative, and ethical (Foster, 1989). He grounded his view of critical leadership in critical social theory. In his 1986 book *Paradigms and Promises: New Approaches to Educational Administration*, he described the focus of critical social theory:



This, at its heart, must be the purpose of a critical theory; it is *not* oriented toward either a return to the past or a destruction of the present. It is oriented toward the possibilities of the future, a future in which all can participate equally. (p. 73)

The search for the possible, with the goal of social justice was the essence of Foster's critical leadership. The next section of the chapter looks more closely at Foster's critical leadership and its critical, transformative, educative, and ethical components.

### ***Foster: Leadership as Critique***

Foster's view of *critical* nature of leadership was based in his belief that human activity is socially constructed. However, his view of the social construction of reality went beyond the interpretivist view where individuals create their own worlds. The worlds created in a critical approach:

...assume a historical structure in which arenas of power, and thus domination, become a major factor. Individuals do not just construct their realities in consort with others; they do so in the context of historically determined social structures that constrict free consciousness and serve the interests of only some individuals. (Foster, 1986, p.57)

To Foster, humans were agents who could critically reflect on their lives, rather than simple objects of scientific inquiry. Leadership involved self awareness and self critique. He quoted Grab (1984):

In pointing to the critical spirit as the ground of leadership, my intent has been to argue that without that willingness to examine one's own life, alleged leaders in any and all areas of human endeavor must, of necessity, become identified with their purposes, purposes which inevitably congeal into fixed practices or dogma. In short, potential leaders without this ground find themselves in the service of fixed ideas or causes, and thus agents of the use of power on their behalf. *No longer nourished by a wellspring of critical process at its center, leadership 'dries up' and becomes, finally, the mere wielding of power on behalf of static ideals.* (p. 270, emphasis in the original). (Foster, 1989, p.51)

Thus Foster saw the critical aspect of leadership directed internally at reflection about purposes and goals. However, critical reflection was also directed at analysis of organizational structures, reconceptualizing them through filters of freedom and democracy. It was the commitment of leadership to ideals of freedom and democracy that Foster saw as *transformative* in nature.

### ***Foster: Leadership as Transformation***

According to Foster (1986), *transformative* leadership was oriented to social change, directed at making a difference in regionalized and incremental stages, and ultimately at a societal level. Foster saw leadership as having two concerns:

[Leadership's] twin concerns of empowerment and transformation focus on the same goals as the spirit underlying critical theory—to release us from our prisons of ideology and to give vision. Empowerment shares power by modifying those hierarchical structures that set up false distinctions among their members: empowerment enables unrestrained discourse. Transformation communicates message and symbol beyond our current achievements: it provides a vision, a vision of a just and equal social order. Leadership is the process of transforming and empowering. (1986, p.188)

The transformative and empowering aspects of leadership were a major component of Foster's critical leadership perspectives.

### ***Foster: Leadership as Education***

Humans, in Foster's eyes, were located in their place in history, and as such, place became tradition. Of this tradition he said:

We are both victims and beneficiaries of this tradition: on the one hand, it closes down many options for living free and independent lives; on the other hand, it provides meaning and a sense of place for those lives we do live.

But while tradition can provide meaning, it can also be oppressive. This is why education is such an important part of leadership. To the degree that leadership can critique traditions which can be oppressive, and aims for a transformation of such conditions, then it must be educative. (Foster, 1989, p. 53)

Such education was directed, in Foster's view, at reflection upon institutional structures “to reveal the taken-for-granted features of institutional life and to allow for commentary on the ways and means that the institution either restrains or promotes human agency” (Foster, 1989, p.54).

Foster saw *vision* as a key component of the educative process of leadership. Not content to reflect on and critique existing practices, he saw that it was necessary to have a view of the potential, the possibilities for change. This vision was best presented in

narratives, life stories that connected the past and the retelling of the possible narratives of the future.

The educative aspect, in other words, attempts to raise the followers' consciousness about their own social conditions, and in doing so to allow them, as well as the 'leader', to consider the possibility of other ways of ordering their social history. (Foster, 1989, p. 54)

Thus through the retelling of stories and engaging in the possibilities for the future, educative approaches to leadership created a vision of what was possible.

***Foster: Leadership as Ethics***

Foster saw leadership as predicated on moral relationships intended to “elevate people to new levels of morality” (Foster, 1989, p.55) and a new moral consciousness regarding their situation. He identified the significance of the use of the power provided by virtue of leadership. Power could be used in a negative fashion to achieve the ends of the leader for the benefit of the leader—power wielding.

This use of power to achieve an individual's ends only often results in treating people as means rather than ends-in-themselves. Treating people as means is to dehumanize them, yet this is often the result of 'leadership' training programmes which see the task as the end and the person as the means to accomplish that end. (Foster, 1989, p.55)

Morality, for Foster, transcended the personal. It was not sufficient to be personally moral. A leader needed also to be a “cause of civic moral education which leads to self-knowledge and community awareness” (Foster, 1989, p. 56). He concluded:

This is a central, defining aspect of leadership: leadership which is ethically based takes on the task—indeed a shared task among community members and leaders—of critique and vision: critique in the sense that it remains unsatisfied with social conditions which are either dehumanizing or threatening, and vision in the sense of searching for a kind of life which realizes more closely the Aristotelian ideal. (p.56)

Foster's view of the Aristotelian ideal, that of providing the good life of people as a whole, combined his sense of morality with his goal of social justice. Foster's views on leadership created a conceptual framework for critical leadership. Critical, transformative, educative, and ethical approaches formed the basis of the conceptual approach to critical leadership that was the focus of this study.

### ***Supporting Approaches to Leadership***

The themes of critique, transformation, education and ethics were found to some degree in other popular approaches to values-based leadership. Leadership literature from the, transformational, transformative, inclusive, servant, social justice, authentic and moral/ethical/vocational approaches was analyzed, compared and contrasted with Foster's view of critical leadership. These particular approaches were addressed because they focus on some or all of the aspects of leadership that were pertinent to this study: relationships, character, values, and justice.

### ***Transformational Approaches to Leadership***

The concept of transformational leadership was first popularized by James MacGregor Burns in his 1978 seminal work, entitled *Leadership*. This work was significant because it focused on the interactive relationship between leaders and followers (Magliocca & Christakis, 2001). Burns identified two types of leadership models: *transactional* models, based on transactions and exchanges between leaders and followers, and *transforming* models, which resulted in a relationship of mutuality and stimulation (Magliocca and Christakis, 2001).

McFadden et al. (2005) viewed both transactional and transformational leadership as power and influence theories, based on social exchange. Transactional leadership was viewed as a bargaining process between leaders and followers whereby "followers accept change and tolerate a leader's behavior that differs from their expectations more willingly if leaders first demonstrate their expertise and conformity to the group's norms" (p.72).

Transformational leadership, according to McFadden et al. (2005), surpassed this simple relationship. Transformational leadership was based on values such as liberty, justice, peace and humanitarianism. Despite its focus on values, transformational leadership was still imbedded in relationships of power and influence, based on inspiration and charisma.

Foster (1989) credited Burns with infusing leadership studies with an ethical focus:

Burn's work has been a significant advance in leadership studies. He has looked at the idea of leadership from a moral and value-driven basis, and has not accepted a view of leadership as a simple managerial tool. In his

formulation, history and politics become a driving force, shaped by individual action. In this way, Burn's work rescues leadership from the more technocratic interpretations of the concept. (p. 41)

In focusing the interplay between leader and follower, Magliocca and Christakis (2001) felt that Burns "...opened up the study of leadership to the dynamics of conflict and power, collective purpose, intended real change, and the importance of a moral foundation of leadership and followership"(p.260). They asserted that post-industrial knowledge-based organizations required a shifting of power relationships. The knowledge necessary to solve problems was no longer based on positional power in hierarchical structures, but was dispersed throughout complex organizations. Transformational leadership, with its focus on relationships, invited participation of all members of the organization based on knowledge, reason and processes of learning (Magliocca & Christakis, 2001).

Many contemporary authors and researchers have embraced the relational and moral aspects of Burn's work. In their research, Eddy and Vanderlinden (2006) identified five themes in the work of transformational leaders. Transformational leaders were viewed as leaders committed to teamwork and shared governance; who value people as team members and individuals; who motivate; who have strong personal values; and who have a vision for the organization.

While the concept of transformational leadership constituted a major contribution to leadership studies, there were critics of some aspects of Burns' approach. Foster (1989), while praising Burns for his infusion of ethics into the discussion of leadership, found that his approach lacks "a critical focus"—that it failed to sufficiently focus on critique and change, and lacked the "critical assessment of current situations and an awareness of future possibilities"(p. 43). McMahon (2007) asserted that, while transformational leadership may have focused on ethical and moral approaches within the organization, it failed to question the organizational goals, and how they are met.

Magliocca and Christakis developed a definition of transformational leadership based on the work of Burns, and infused their view with the critical perspectives as developed by critical theorists such as Foster:

Transforming leadership is a learning process of moral and spiritual consciousness that constructs equitable patterns of power relations among leaders and followers to achieve a collective purpose of intended, real transformation of the organization or social system through authentic participative design. (2001, p. 263)

This definition pushed beyond the margins of the organization and invoked the possibility of action at the level of society. This approach was synonymous with Foster's views on critique and transformation in search of social change.

### ***Transformative Approaches to Leadership***

Intent on imbuing leadership with the critical perspective of social change, and consistent with Magliocca and Christakis's reinterpretation of Burns' original definition of transformational leadership, a prominent U.S. writer in the area of leadership and transformation in the field of Educational Administration, Carolyn Shields (2004b) reconceptualized leadership as *transformative*, rather than *transformational*.

I use the term *transformative* and not the more commonly used term *transformational* to signify that the needed changes go well beyond institutional and organizational arrangements. Transformational leadership...focuses on the collective interests of a group or organization. Transformative leadership is deeply rooted in moral and ethical values in a social context. (p.113)

Quoting Astin and Astin (2000), Shields defined how transformative leadership leads to changing society.

We believe that the value ends of leadership should be to enhance equity, social justice, and the quality of life; to expand access and opportunity; to encourage respect for difference and diversity; to strengthen democracy, civic life, and civil responsibility; and to promote cultural enrichment, creative expression, intellectual honesty, the advancement of knowledge, and personal freedom coupled with responsibility. (Astin & Astin, 2000, p.11)

In Shields' view, the critical challenging of the status quo ought to be overtly articulated as a key aspect of transformative leadership. Also key to her conceptualizing of transformative leadership was the "centrality of relationships" and the concept of "leadership as facilitation of moral dialogue" (Shields, 2004b, p.114).

Dialogue is therefore central to the task of educational leadership—not a weak concept of dialogue interpreted as strategies for communicating but

a strong concept of dialogue as a way of being. Dialogue and relationships are not elements that can be selected and discarded at will; rather, they are ways of life—recognitions of the fundamental differences among human beings and of the need to enter into contact, into relational dialogue and sense making (participating with our whole being) with one another. Thus conceived as ontology, dialogue opens each individual educator to differing realities and worldviews. (Shields, 2004, p. 116)

From Shields' perspective, dialogue was relational in nature, directed toward discovery and new understanding. In her view, dialogue was not always free from tension, but it was always grounded in “norms of inclusion, respect, and a commitment to excellence and social justice” (2004b, p.116).

Shields' view of leadership as critical (reflective), transformative (challenging of the status quo), educative (based on dialogue to advance understanding), and ethical (directed toward values of equity, social justice, inclusion, democracy and valuing of difference) placed her transformative leadership model well within the umbrella of critical leadership as described by Foster. Transformative leadership themes are revisited in the discussions of leadership for inclusion and leadership for social justice that follow.

### ***Inclusive Approaches to Leadership***

Perhaps the most noted writer on inclusive leadership is the Canadian author James Ryan. Ryan's views on inclusive leadership were developed in relation to education (Ryan, 2003; Ryan, 2006a; Ryan, 2006b). Leadership, for Ryan, was a relational, not a positional, process. Inclusion, in Ryan's view, was both a leadership goal, and a leadership process. He articulated the need for inclusion as a *goal* in his assertion that increasing diversity in the school population has resulted in greater separation between the advantaged and the disadvantaged (2006b).

For Ryan, the promotion of inclusion was a way of achieving social justice. Social justice could be achieved “if people are meaningfully included in institutional practices and processes” (2006b, p. 5). In Ryan's view, when people were denied resources, participation, and customary living conditions, they were denied social justice. Thus exclusion was not an issue of the individual, but a collective issue, to be addressed at a structural level. Advocates of the view that exclusion impeded social justice

...contend that structural processes, rather than individuals or groups systematically create barriers and inequities that prevent the social advancement of the poor, disempowered and oppressed and ultimately inhibit the fair distribution of goods. Social justice will be achieved, then, only when changes to the system allow for meaningful inclusion of everyone, particularly those who are consistently disadvantaged and marginalized. (Ryan, 2006b, p.6)

Leadership from a *process* perspective was viewed as a collective means of social influence aimed at a particular end. In this process, everyone was fairly represented (2006a). Inclusive leadership can be summarized thusly:

We need to look on leadership as a collective influence process that promotes inclusion. Such leadership is inclusive in two ways. First, the process itself is inclusive; it includes as many individuals and groups and as many values and perspectives as possible in decision making and policymaking activities. Second, inclusive leadership promotes inclusive practices. Inclusive leadership is organized above all to work for inclusion, social justice, and democracy, not just in school and local communities but also in wider national and global communities. (Ryan, 2006b, p.2)

Foster addressed leadership as a communal process, one that occurred in a “community of believers” (1989, p.49). He saw leadership as shared and transferred within the community. Ryan took the idea of community and made explicit the inclusive nature of leadership, both in its aims, and also in its process. In this way, Ryan captured an important aspect of leadership not made explicit in Foster’s work. His work added an important fifth concept, inclusion, to Foster’s four dimensions of leadership— critique, transformation, education and ethics.

### ***Social Justice Approaches to Leadership***

Leadership for social justice appeared on the agenda in the educational administration literature in the late 1990s. Furman and Grunewald (2004) described social justice as one of the most powerful “synthesizing paradigms” in the “shifting landscape” of leadership studies in education. In 2004, the *Educational Administration Quarterly* dedicated an entire issue of the journal to discussion of leadership for social justice in educational administration. In the introduction to the issue Catherine Marshall called for social justice to dominate the discourse of the discipline, indicating that leadership in education was unprepared to address inequities, that there was a mismatch



between the profession and its clientele, and that policy directions did not reflect a commitment to social justice (Marshall, 2004).

Leadership for social justice as identified in the educational administration literature was grounded in critical social theory. Adams, Bell and Griffin (2007) stated

Social justice is both a process and a goal. The goal of social justice is full and equal participation of all groups in a society that is mutually shaped to meet their needs. Social justice includes a vision of society in which the distribution of resources is equitable and all members are physically and psychologically safe and secure. We envision a society in which individuals are both self-determining (able to develop their full capacities) and interdependent (capable of interacting democratically with others). Social justice involves social actors who have a sense of their own agency as well as a sense of social responsibility toward and with others, their society, and the broader world in which we live. (pp. 1-2)

Social justice was directed at redressing institutionalized inequality and systemic discrimination (Lunenburg, 2003). Theoharis (2007) described leadership for social justice as occurring when leaders made issues of marginalization on the basis of race, class, gender, disability, and sexual orientation, essential to their advocacy, leadership practice and vision. Leadership for social justice was inherently moral. Brown saw leadership as an enactment of values (Brown, 2004).

Leadership for social justice was inherently active (Roby, 1998). Brown (2006) addressed the importance of moving beyond awareness and self awareness with respect to issues of social justice, to social action, based on Freire's view that a commitment to social justice "entails advocacy, solidarity, an awareness of social structures of oppression, and critical social consciousness" (p.703).

Critical reflection was seen to be crucial to leadership for social justice. Reflection and challenging of one's beliefs was seen as the first step in the social justice process (Brown, 2006). The purposes of critical reflection were to "externalize and investigate power relationships and to uncover hegemonic assumptions" (Brown, 2004, p.84).

Effective leadership for social justice was seen as not only reflective, but also dialogic, according to Shields (2004b). Moral dialogue and strong relationships formed the basis of leadership for social justice from Shields' perspective. This centrality of relationships was a major feature of leadership for social justice. Shields viewed dialogue

as relational, aimed at discovery and understanding (Shields, 2004b). Magliocca and Christakis (2001) talked about leadership as a process giving “voice” to all.

The purpose of dialogue, and giving voice, was “...to stimulate doubt, criticism, curiosity, questioning, a taste for risk-taking, the adventure of creating” (Freire, 1973, p.50). Dialogue formed the basis of the process of *conscientization* or development of critical consciousness, as defined by Freire. Conscientization began with critical reflection and dialogue, “whereby people perceive[d] the social, political, and economic contradictions of their time and [took] action against the oppressive elements” (Brown, 2006, p.710).

For Brown (2004), leadership in times of injustice was inherently challenging. The transformative nature of leadership for social justice does not shy away from the conflicts embedded in the situation. Brown (2004) stated that dealing with the difficult issues of social injustice:

...underscores the urgent need to confront socially difficult topics with respect, dialogue, and a continuous expansion of awareness, acknowledgement, and action. Developing the vocabulary, skills, and knowledge necessary to engage in substantive discussions concerning the dynamics of difference is a critical component in the preparation of leaders for social justice and equity. (p. 80)

While separated out here for the purposes of discussion, the educational administration literature on leadership for social justice clearly met the criteria for critical leadership as laid out by Foster. It was specifically identified and addressed in this study because, while there was nursing literature addressing the topic of social justice, nothing was found in the nursing literature addressing the topic of leadership for social justice. This literature, in conjunction with the work of Foster and Ryan, directly informed the approaches to leadership that evolved during the research design and data analysis processes of this study.

### ***Leadership as Vocation***

The literature addressing leadership as vocation approached leadership from a *moral* perspective. The theme of moral or ethical leadership was addressed by numerous contemporary writers in the field of leadership. Campbell (2007) approached leadership

from a moral perspective in her exploration of the *character* of leadership. Character, according to Campbell, included integrity, values, motives, and vision. Leo and Barton (2006) defined moral leadership as speaking to "...notions of purpose and human action, addressing what is morally purposeful for leadership to do" (p. 171).

Eddy and vanDeLinden (2006) addressed values-based leadership in the post industrial era, evoking values of "collaboration, common good, global concern, diversity and pluralism in structures and participation, client orientation, civic virtues, freedom of expression in all organizations, critical dialogue, qualitative language and methodologies, substantive justice, and consensus-oriented, policy-making processes" (p. 7).

*Leadership as vocation* was addressed directly by Pence (2003). Of leadership as vocation, he stated "...we will need people who combine the skills of 'how to' with the calling of 'why do'" (p.38). The *calling* inherent in the term vocation implied knowing "who one is, what one believes, what one values, and where one stands in the world" (Pence, 2003, p 39).

Linked closely to Pence's view of calling was Campbell's (2007) view of the *spirituality* associated with leadership. She defined spirituality as "an intangible animating force involving a state of intimate relationship with a force beyond oneself, an awareness of one's inner self, and recognition of a connection with other people" and went on to say "Spirituality is viewed as a holistic connectedness of self, others, and context, with its interconnectedness as its epitome"(Campbell, 2007, p.143). Spirituality, according to Campbell, had two aspects: the sense of vocation or calling to one's work that results in a sense of meaning, similar to that expressed by Pence, and "a need to be connected to others and experience membership in a common cause"(p. 143).

Articulating his view of leadership as vocation, Pence (2003) used a moral lens. According to Pence, leadership had as its goal the cultivation of intellectual and ethical judgment, and assisting organization members in building a broader understanding of their relationship to the larger world. Leadership as vocation involved three good practices, according to Pence: the development of vision; the balancing of paradoxes; and keeping hope alive.

**Visioning.** Pence saw the development of vision as requiring occupational skill, knowledge of organizational processes and structures, and a general level of expertise. But it also required the development of beliefs and values that promoted individual and common goods. Pence expected visioning to “create conditions for healthy spiritualities” and to “introduce a constructive restlessness instead of a comfortable satisfaction” (p.185). He cited Senge’s work when identifying the importance of *shared* vision, something which occurred only when there was collective consideration of the goals of the organization (Pence, 2003).

The aspect of creating moral discomfort introduced in Pence’s work was echoed in Brown’s discussion of leaders who were willing to “leave the comforts and confines of professional codes and state mandates for the riskier waters of higher moral calling” (2006, p.702). Such leaders understood that leadership embodied *values in action*.

Barendsen and Gardner (2007) similarly linked ethical vision and action in articulating three distinct aspects of good leadership. Their research showed that the best leaders had excellent technical and professional skills, an ethical orientation, and “a completely engaged sense of fulfillment and meaningfulness” (p. 21).

**Balancing paradoxes.** In Pence’s (2003) view, problems were more effectively viewed as paradoxes:

Problems ... demand solutions, calling for the powers of analysis, reason, logic, environment, testing, validity, and so forth. In a problem solving environment, people seek solutions. When they find solutions, they claim victory; when the solutions escape them, they feel defeat. Then they look for someone else to blame. (p. 39)

Paradoxes, on the other hand, were seen as messy. If problems were viewed as paradoxes, the complexity and challenge of the seemingly impossible potential for solutions left one with the view that they could not be solved—they must be lived through. It was this “living through” that produced the learning that was part of vocational leadership, as Pence defined it.

**Keeping hope alive.** The third aspect of vocational leadership as developed by Pence related to keeping hope alive in the face of organizational chaos, cynicism,

skepticism, and doubt. Vocational leadership "...requires the courage to question practices and policies that diminish the commitment to excellence" (Pence, 2003, p.43).

Leadership, according to Gardner (2003) was inextricably linked to hope:

Creativity within an organization or society is to be found among men and women who are far removed from the fatalistic end of the scale. They have a powerful conviction that they can affect events in some measure. Leaders at every level must help their people keep that belief. There are all too many factors in contemporary life that diminish it. (Gardner, 2003, p. 86)

These views of the centrality of hope in leadership were supported by Walker (2006). He proposed that fostering hope was the most essential act of leadership—the "first and last task" of leadership (p. 540).

The centrality of hope was a theme in Paulo Freire's 1994 work, *Pedagogy of Hope*. He discussed the impact of a lack of hope:

When it becomes a program, hopelessness paralyzes us, immobilizes us. We succumb to fatalism, and then it becomes impossible to muster the strength we absolutely need for a fierce struggle to recreate the world.

I am hopeful, not out of mere stubbornness, but out of an existential, concrete imperative.

I do not mean that, because I am hopeful, I attribute to this hope of mine the power to transform reality all by itself, so that I set out for the fray without taking account of concrete, material data, declaring "My hope is enough!" No, my hope is necessary, but it is not enough. Alone, it does not win. But without it my struggle will be weak and wobbly. We need critical hope the way a fish needs unpolluted air. (p.2)

These ethical, moral and vocational leadership approaches resonated with much of Foster's work. Foster embraced the visioning aspect of leadership:

It is not enough to reflect on current social and organizational conditions; in addition, a vision of alternative possibilities must be addressed. Such a vision pertains to how traditions could be altered, if necessary, so that they meet human needs while still providing a sense of meaningfulness. This is perhaps the most crucial and critical role of leadership: to show new social arrangements, while still demonstrating a continuity with the past; to show how new social structures continue, in a sense, the basic mission, goals and objectives of traditional human intercourse, while still maintaining a vision of the future and what it offers. (Foster, 1989, p.54)

While these ethical, moral and vocational views of leadership were clearly educative (living through paradoxes) and ethical (rooted in building vision and fostering hope) in the tradition expressed by Foster, they were perhaps, with the exception of Freire, less explicit in their critical and transformative aspects. While Foster called for critical transformative change with respect to the status quo, these approaches had a more interpretive approach to current conditions. While these approaches informed the study design and data analysis, they were supplemented in forming the conceptual design of the study by critical, reflective and transformative leadership literature.

The positive, optimistic approaches evident in moral approaches to leadership were also seen in two other popular approaches to leadership—those of authentic leadership and servant leadership.

### ***Authentic Leadership***

The concept of authentic leadership was based in the positive tradition. Positive psychology and its associated positive organizational studies were directed at “understanding positive human processes and organizational dynamics that make life meaningful” (Ilies, Morggeson, & Nahrgang, 2005, p. 374). Iles et al. (2005) indicated that the positive tradition of study differed from traditional approaches in that it strove to find that which represented what is “the best of the human tradition”(p.374).

Authenticity involved owning one’s personal experiences and acting in accordance with one’s true self. Authenticity was rooted in Greek philosophy—to thine own self be true (Avolio & Gardner, 2005). Authenticity focused on the development of fully functioning or self actualized human beings, “individuals who are ‘in tune’ with their basic nature and clearly and accurately see themselves and their lives” (Avolio & Gardner, 2005. p. 319).

Strong ethical convictions were the hallmark of authenticity (Avolio & Gardner, 2005). Speaking of authenticity in relation to education, Starratt (2005) stated:

Authenticity, the way of being real, is a moral good. The learner always pursues this way of being real, this way of expressing her or his moral goodness, in relationship to the realities of the worlds he or she inhabits, the truths of which are revealed through the activity of learning. (p. 405)

According to Ilies et al. (2005), authentic leadership was ultimately directed at the establishment of positive relationships. Authenticity relied on the character of the leader in the establishment of these positive relationships (Campbell, 2007). Authentic leadership focused on positive modeling as the major mechanism by which leaders established relationships and impacted followers:

...Authentic leadership focuses on the character of the leader as the driver of positive interrelationships with followers...authentic leaders are described primarily in terms of their character in that they know who they are, what they believe and value, and they act upon those values and beliefs while transparently interacting with others. (Campbell, 2007, p.140)

Leadership based on authenticity was relational and moral, but largely introspective in relation to the organization in which it was based, and did not address societal change. While critical leadership was directed ultimately at changing power structures within and outside of organizations, authentic leadership focused more on the internal harmony and positive relationships within the organization. Authentic leadership was a focus of leadership for several of the leaders studied, and for this reason this literature was reviewed for this study.

### ***Servant Leadership***

The servant leadership literature was reviewed because of its strong ethical orientation. The literature on servant leadership situated the concept in the positive tradition of authentic leadership, but took the relational aspect of authentic leadership one step further. Robert Greenleaf introduced his conceptualization of the servant leader and servant leadership in 1970 (Greenleaf, 1991). While Greenleaf was credited with articulating the modern conceptualization of servant leadership, many writers situated servant leadership in the actions and teachings of Jesus Christ (Coulter, 2003; Sendjaya & Sarros, 2002). Greenleaf's conceptualization of servant leadership was a prominent and important leadership construct addressed in the Christian literature on leadership (Coulter, 2003).

The foundation of Greenleaf's approach was one of affirmation and belief in the positive nature of human beings. He viewed leadership as service to followers. The true

test of leadership for Greenleaf was whether it fostered growth in those it served. The effectiveness of leadership was measured by whether

...those served grow as persons, when they, *while being served*, become healthier, wiser, more autonomous, more likely themselves to become servants. And, what is the effect on the least privileged in society? Will they benefit or at least not be further deprived? (Emphasis in the original. Greenleaf, 1977, pp. 13-14).

Servant leaders placed the needs of others before their own. Their motivation was not one of leadership but of service first.

It begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead.... The difference manifests itself in the care taken by the servant—first to make sure that other people's highest-priority needs are being met. (Greenleaf, 1977, p.13)

Sendjaya and Sarros (2002) saw distinct parallels between Greenleaf's servant leadership approaches and the transformational leadership approaches of Burns, who stated

[Transforming] leadership occurs when one or more persons engage with others in such a way that leaders and followers raise one another to higher levels of motivation and morality... But transforming leadership ultimately becomes *moral* (emphasis in the original) in that it raises the level of human conduct and ethical aspiration of both leader and led, thus it has a transforming effect on both. (Burns, 1978, p.20)

A 17-year director of the Greenleaf Center for Servant Leadership, Spears (1995) identified ten characteristics of servant leadership based on his readings of Greenleaf's work: listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of people, and building community (Avolio, Walumbwa & Weber, 2009; Sendjaya & Sarros, 2002; Spears, 1995).

While servant leadership was seen as ethical in its goal of moral development of all involved, and educative in its supportive approaches to development of leaders and followers, servant leadership articulated what Smith, Montanegno and Kuzenko (2004) deemed a *spiritual generative culture*, one where

Members are focuses (*sic*) on the personal growth of themselves and others, and the organizational systems that facilitate that growth. It is further suggested that, while this culture is satisfying to organizational members, it results in followers who are passive to the external



environment and unlikely to want to upset internal conditions which might require substantive changes in the status quo but is conducive to generating internal personal growth. (p. 86)

In its basic form then, servant leadership, as was the case with authentic leadership, was not viewed as inherently critical or transformative in nature. Servant leadership did not *require* critical transformation and changing current power imbalances in society. This did not preclude the use of concepts of servant leadership in tandem with a critical focus. Servant leadership could in fact *support* transformation. Servant leaders could possess commitments to transformation and critique that impacted their application of servant leadership, but such approaches were not inherent in servant leadership per se.

In conclusion, Foster's views on critical leadership were supported by leadership studies in many genres. Comparing transformational, transformative, inclusive, social justice, vocational, authentic and servant leadership approaches to leadership with Foster's work enhanced it and strengthened my understanding of leadership that supported and demanded changes both within organizations and beyond. These comparisons also helped me to interpret the stories of the leaders in this study in a meaningful way, and for that reason this literature is included here.

### ***Critical Leadership and Nursing***

After reviewing the nursing literature that related to leadership, I reached two conclusions: The nursing literature on leadership was actually primarily about management; and nursing did not have the rich body of literature on critical leadership, transformative leadership and leadership for social justice found in the education literature.

Management theories and studies abounded in the nursing literature. The literature was replete with texts and articles addressing the technical "fix it" aspects of management. Even authors who addressed power relationships in leadership (Chinn, 1996; Chinn, 2008) and those who used the language of transformational leadership (McGuire & Kennerly, 2006; Registered Nurses Association of Ontario [RNAO], 2006; Reinhardt, 2004) focused largely on managing the technical issues *within* the profession and in the organizations in which nurses work, and did not address the larger issues of social change beyond the profession and health care organizations. Antrobus and Kitson

(1999), in one of the few studies concentrating on the social change, transformational nature of leadership in nursing, stated:

Where previous work on nursing leadership has taken place, it has on the whole been internally referenced. That is, it has been concerned with the nature and purpose of leadership..., leadership styles..., leadership characteristics..., and the development needs of those who aspire to leadership positions.... Nursing leadership has been viewed to be an internal professional concern and not as having an external focus. (pp. 746-747)

While there was little literature in nursing focusing on *leadership* for social change, social transformation, or social justice, such as was evident in the education literature, there *was* a body of literature addressing social justice in relation to the *recipients* of nursing services, and the history of social justice within the profession. In the absence of literature dealing with leadership for societal transformation, social change or social justice in nursing, I opted to look at these nursing approaches to societal change and social justice in general. I did this in order to understand the view of the nursing profession in its role in bringing about societal change and social justice. Understanding how nurses approach social justice for their clients served to inform me in my quest to understand the stories and experiences of leaders who acted to increase the participation of underrepresented groups in the profession. I looked first at the literature addressing social justice in nursing, and then reviewed the limited writings that address critical leadership within the profession.

### ***Social Justice in Nursing***

A review of the literature found historical commitment to and involvement in social justice in nursing, dating back to the work of Florence Nightingale (Drevdahl et al., 2001; Falk-Raphael, 2005; Kelley et al., 2008). Nightingale championed the role of nurses in social reform around environmental issues in her developmental work within the profession. Kelley et al. (2008) stated:

Nightingale was the first to “stake out” nurses’ responsibility to address the relationship between society and health. Her ability to connect illness and death with social conditions, and to advocate change at societal levels, set the stage for integration of social responsibility into the education and practice of nurses. (p. 4)

The history of public health nursing was strongly linked with a social justice commitment. Indeed, some authors cited social justice as the core of public health nursing (Drevdahl et al., 2001). Nursing leaders such as Lillian Wald, Margaret Sanger and Lavina Lloyd Dock were politically active around issues of sanitation, housing, education and women's health, particularly birth control. Rooted in the suffrage movement, they were well acquainted with political tactics aimed at social change (Drevdahl et al., 2001; Falk-Raphael, 2005; Kelley et al., 2008). Bekemeier and Butterfield (2005) indicated that "Wald, Dock, and Sanger grew indignant from witnessing the destructive outcomes of institutionalized poverty and of gender and ethnic inequalities. These nurses harnessed their indignation to work toward the creation of progressive health care policies" (p.153).

There was general agreement in the literature that the history of nursing contained its nursing activists and advocates for social change (Bekemeier & Butterfield, 2005; Drevdahl et al., 2001; Kelley et al., 2008). This activist history was reflected in early versions of many foundational nursing documents in countries such as Australia, the U.S. and Canada (Bekemeier & Butterfield, 2005). These documents, including Codes of Ethics for Nurses and social policy statements (CNA, 2008b; American Nurses Association [ANA], 2005) historically contained language that spoke of social justice and committed the profession to social action. Kelley et al. (2008) believed that this language, found in documents that are foundational to nursing practice, made explicit the obligation of the profession to participate in action toward social justice:

Nurses stand at a privileged intersection in which they simultaneously provide care to patients and witness the larger societal forces that either impede or enhance the attainment of the patient's health. Consequently, if nurses are to fulfill their professional responsibilities, they are obligated to attend to the social structures that affect patients' health. This obligation is deeply rooted in nursing's identity as a profession and its contract with society through which the profession is accorded trust in exchange for its work on behalf of society's well-being. (p.4)

The belief that nursing had a social contract that compelled it to social action was reiterated by Ballou (2000); who indicated that "If a profession established a relationship with citizens or its clients based on a social contract, it is morally obligated to uphold justice within its particular domain and to use sociopolitical force to do so" (p.175). She

went on to say “based on their primary commitment to patients, nursing is morally obligated to address the powerful forces hindering their mission” (p.175).

Despite the appearance of social justice language in nursing codes of ethics, and the view that action toward social justice was an obligatory part of nursing, there was evidence in the literature that nurses did not consistently act to achieve social justice. Nurses were generally viewed as strong supporters of the existing social order (Falk-Raphael, 2005). Ballou (2000) indicated that “There is abundant evidence that professional nurses, individually and collectively, are minimally involved in sociopolitical activities at any level” (p.181). Hardill (2007) noted that nurses have traditionally avoided political action, and when they did act, their actions were based on the naïve view that informing the power structures of health issues would result in action, as if health issues existed due to simple lack of information on the part of society’s planners.

Some authors attributed this contradiction between the social justice and social activist history of the profession and its current limited role in social justice to the loss of the *societal* aspect of health and illness that occurred when the medical model emerged as the primary model for health care delivery (Drevahl et al., 2001; Kirkham & Browne, 2006). The focus of the medical model on the *individual*, and its deficit-based single disease or organ system approach to organization of health interventions, resulted in a loss of focus on the bigger-picture, holistic aspects of health. The medical model favored a problem-solving approach at the level of the individual. Drevahl et al. (2001) attributed the rise of this individualistic focus to the increasing domination of the health care system in the early 1900s by the medical profession:

Medicine’s adoption of a reductionist, disease focus on health influenced public health, as well as how nurses and other ...citizens conceptualized health. Medical domination of public health solidified following World War I, during which time the American Medical Association criticized public health nurses for practicing policies that were seen as wasteful, extravagant, and promoting communism. Consequently, increasing numbers of public health nurses found themselves working in physician-dominated bureaucracies that centered, once again, on the ill individual rather than on the concerns of larger groups and populations. (p. 21)

The medical model, with its hierarchical, mechanical approach to disease required solutions on a one-on-one basis, rather than solutions based on social transformation.

As I outlined in my previous discussion of pluralistic views of multiculturalism, Kirkham and Browne (2006) attributed this individualistic focus not only to the influence of the medical model, but to the grounding of the nursing view of social justice in the liberal tradition of the primacy of the individual. They challenged a distributive view of justice that simply pitted individuals against each other in attempts to access equity within the existing paradigm. They stated:

Rooted in liberal ideological notions about society as compromising freely choosing individuals who exist in an essentially egalitarian environment, individualism views structural constraints as a given. Rather than working to change these constraints, the goal is to *support* individuals to cope with their situation or make healthier choices. When health is primarily conceptualized as an *individual* responsibility, it is difficult to operationalize a social mandate for nursing focused on addressing social conditions that constrain opportunities for health. (Kirkham & Browne, 2006, p. 330)

Bekemeier and Butterfield (2005) saw this focus on the individual as “reinforcing the ‘think small’ position”, a practice that:

...narrows nursing practice to that which is less complex and more manageable—focusing on the behaviors of individual patients rather than the system that has compromised them. This focus on the individual assumes the locus of health problems to be with the patient or community rather than largely a function of the social environment and unsupportive (at best) or deleterious (more likely) systems. Besides having little or no effect on large-scale health outcomes, this approach minimizes possibilities for real change, because when our energies are fully spent elsewhere, simple opportunities for participation and leadership in social action go unnoticed or without effort. (p.158)

The “thinking small” approach to the role of nursing in relation to society was evident in recent events surrounding the revision of the *Canadian Nurses Association Code of Ethics for Nurses*. The previous *Code of Ethics*, published in 2002, included the value of justice as one of eight values that were foundational to nursing practice. The values in the 2002 code were “grounded in the professional nursing relationship *with individuals* and indicated what nurses care about in that relationship (emphasis added)

(CNA, 2002, p.7). Thus the 2002 code was based in the one-on-one nurse patient relationship. This focus was further demonstrated in the definition of justice provided in the Code, “Nurses uphold principles of equity and fairness to assist persons in receiving a share of health services and resources proportionate to their needs and in promoting social justice” (p. 8). The language of *maneuvering* within the *existing* framework was evident—*assisting*, and *receiving shares of existing services*, rather than *promoting fundamental change* in the *system* itself.

Despite the focus of the 2002 code on the micro level of the nurse-patient relationship, the code did include a statement about “promoting social justice,” allowing a small window of hope that nurses and nursing professional associations might be called by their professional code of ethics to take up the historical practice of social activism to achieve change. The revision to the Code in 2008 closed that window firmly.

The *2008 Code of Ethics* was restructured. The Code was divided in to two sections; ethical *responsibilities*, and ethical *endeavours*. While retaining justice as one of the foundational values or ethical responsibilities, the concept no longer included any reference to justice at a *societal* level. Issues related to social justice, such as the social determinants of health, working with vulnerable populations, practicing health promotion and awareness of global health issues were captured and corralled in a section separate from the ethical responsibilities of the profession. They were assigned to a section of the Code called *ethical endeavours*. Ethical endeavours were defined as “endeavours that nurses can undertake to address social inequities” (CNA, 2008, p.3). Nurses were encouraged to “endeavour, *as much as possible*, individually and collectively, to advocate for and work toward eliminating social inequities” (p. 20, emphasis added).

The rationale behind this change related to the role of the document. While some felt that a code of ethics was an aspirational document, others saw its existence as a regulatory measure, one that could be used to evaluate the practice of individual nurses. From a regulatory point of reference, since nurses did not have control over social justice, it was not considered fair to hold them accountable for this aspect of their practice. In an attempt to accommodate both of these views, the code was divided into two parts (Peter, 2008).

According to Peter (2008), the new structure of the CNA code undermined professional commitment to social justice. “The term ‘endeavour’ carries much less moral weight than “responsibility” because an endeavour could imply simply an attempt, while a responsibility is more firmly a requirement. The structure of the new framework implies to nurses that the ‘ethical endeavours’ are less important than the ‘core ethical responsibilities’” (p. 29).

So, despite the already minimized, individually focused, language of the 2002 document, the 2008 document was stripped even further of the potential for collectively focused action directed at transformative change. Nurses, could, if so inclined, and when possible, advocate for justice for their clients.

Kirkham and Browne (2006) rejected the individualistic focus of the one-on-one nurse patient relationship as the center of social justice in nursing practice. They supported a *critical* approach to social justice, one which advocated transformative change at a societal level. A critical approach to social justice, as we saw with critical approaches to multiculturalism, challenges the underlying societal structures, rather than “maneuvering within injustice” at the individual level (Browne, 2001). Kirkham and Browne indicated:

The emphasis on *fairness* in the allocation of resources to individuals, *access*, and on *awareness* of wider health concerns reveals a conceptualization of social justice as something that can be achieved without disrupting the current status quo—rather than as a politicized ideal that will require challenging hegemonic structures and practices that operate to maintain the status quo. (Kirkham & Browne, 2006, p. 331)

Critical perspectives on social justice “...address issues of equity vs. equality; conceptualize health as a human right; challenges neoliberal policies; draw attention to racialization, cultural devaluing and discrimination as factors constraining social justice; and generally prioritize collectivism vs. individualism”(Browne & Tarlier, 2008). Falk-Rafael (2005) supported critical approaches to social justice in nursing, stating “Nurses practice at the intersection of public policy and personal lives; they are, therefore ideally situated and morally obligated to include sociopolitical advocacy in their practice”(p. 222). Despite this ideal positioning, such advocacy on the part of nurses is not common current practice.

The literature revealed a differentiation between traditional liberal views of social justice which encourage nursing approaches based on the primacy of the individual and a focus on the nurse-patient relationship, as compared with critical approaches to social justice which unpack structural barriers and power imbalances in an attempt to understand what is needed for true social transformation.

This literature review of social justice approaches in nursing provided a filter through which to view the themes that appeared in the stories of the leaders included in this study. Utilizing this literature allowed me to understand the perspectives of the study participants with respect to their views of social justice and their expectations of the nursing profession's commitment to social justice. It allowed me to understand and analyze the themes of social justice that emerged.

### ***Nursing Leadership for Social Change***

As previously noted, there was limited literature addressing leadership for social justice or social transformation to be found in nursing. Literature on leadership for diversity in nursing was generally limited to calls for increased diversity within the profession, at all levels (Brown, 2004; Chinn, 1996; Huston, 2008). There were brief articles acknowledging the role of African American nurses who provided leadership in desegregating nursing in the U.S. (Houser & Player, 2008) and Canada (Flynn, 2009). However, there was little written specifically about *leadership* to promote diversity and inclusion in the profession, nor was their literature on the broader topic of leadership for social justice in nursing, such as was found in the education literature.

In one of the few articles addressing leadership for social change in nursing, Antrobus and Kitson (1999) referenced the limited nature of the nursing leadership literature that focuses beyond the profession and the organizations in which the profession works to the broader sociopolitical level of society. They noted that leaders were generally focused on developing nursing practice, not health and social policy. They concluded that there was a general *political invisibility* of nursing at the social change and social policy level (Antrobus & Kitson, 1999). Using a critical ethnographic approach, the authors looked at the role played by nurse leaders in establishing health and social policy. They found that nursing leadership had both an internal and an external focus



“that is, effective nursing leadership currently is a vehicle through which *both* nursing practice and health policy can be influenced and shaped” (p. 746).

Four domains of leadership influence emerged from their interviews: political, management, academic and clinical. Leaders reported that, while they may have had one primary focus, they shifted between domains depending upon their responsibilities at any given time. For the participants, “knowledge derived from nursing practice was the central component of their leadership philosophy” (Antrobus & Kitson, 1999, p. 749). They found three main themes that derived from this study.

**Leadership as bridging the policy/practice divide.** Leaders found themselves in an interpretation/ translation mode in order that the position of nursing be translated to others, such as policymakers, in a manner that could be understood. Antrobus and Kitson concluded:

Having interpreted nursing knowledge derived from nursing practice to the domains of political, academic or managerial, the external contextual relationship involved nurse leaders subsequently translating nursing to the language and priorities of politics, academia, or management. The art to this translation seemed to be moving nursing from the invisible to the visible, so that in the translation the ideology and values of nursing were not lost, whilst nursing was positioned within mainstream thinking so that it acquired power and influence. (1999, p.750)

**The bi-cultural nature of nursing leadership.** The study showed that nurse leaders had to feel comfortable and skilled in the culture of nursing practice and the other contexts in which they functioned. They needed to be comfortable “mainstreaming the values of nursing” in their managerial, political and academic roles.

**Skills repertoire.** The following themes emerged with respect to the skill sets required by nurse leaders who successfully negotiated the “bigger picture” world beyond nursing and health care institutions. The profile of a successful leader was as follows: a powerful, influential operator; a strategic thinker who created meaning and facilitated learning; a nursing knowledge developer; a reflexive thinker, who understood self, values, purpose and meaning, and; a process consultant who worked effectively with others on a human level (Antrobus & Kitson, 1999). This study served as the basis for the development in the early part of this decade of the United Kingdom Royal College of

Nursing Political Leadership Programme, which continues to educate nurse leaders currently to influence policy development.

In conclusion, the nursing literature on critical leadership, transformative leadership, and leadership for social change did not match the volume of literature on these topics found in the field of education. In the relative absence of such literature, the nursing approaches to social justice itself provided a backdrop against which the stories of the leaders included in this study were placed. In addition, the work of Antrobus and Kitson provided relevant themes on leadership in nursing directed at policy development at a societal level, beyond the confines of the profession and the agencies in which nurses work.

### **Review of the Literature: Summary and Conclusion**

The framework for this literature review was embedded in three major concepts: diversity, professional closure, and critical leadership. I focused mainly on literature that approached these concepts from a critical perspective— approaches that examined and challenged the existing order and looked at the concepts from the perspective of transformative change. I used this approach to the literature review because it was one that mirrored my approach to study and critical thought in general. Bryman (2004) described the dilemma experienced by qualitative researchers looking at leadership:

For many qualitative researchers on leadership, there is a delicate balance between needing the existing literature as a means of bestowing credibility on and providing a rationale for an investigation, on the one hand, and a commitment to getting at the perspective of those one studies through an open-ended research approach that contaminates the topic as little as possible, on the other. (p. 756)

I attempted to honor this delicate balance in matching this literature review with the design of the study. While I provided a research-based backdrop against which the study was conducted, I tried not to let my choice of direction in the literature review overpower the research design, but simply to lend it some flavor. It is the research design, its structure and processes, and the ontological and epistemological considerations underlying it that are outlined in Chapter Three.

The research design, through its narrative approaches, was intended to validate and further develop the conceptual framework with respect to the concepts of diversity,

professional closure and leadership, and the relationships between these concepts. How did the nurse leader participants view leadership and diversity in nursing? How did their experiences shape these views? Did they experience the professional closure practices outlined in the literature? How did they deal with these practices? Did their views and experiences with leadership mesh with Foster's views on critical leadership, as further informed by Ryan? What other aspects of leadership sustained these leaders in their drive for equity within the profession? This study linked the experiences of these nurse leaders and the stories that arose from these experiences with the literature in an attempt to further develop and refine, or perhaps revisit, the conceptual framework as outlined in the early part of this chapter.

## **CHAPTER THREE: RESEARCH METHODOLOGY**

### **Introduction and Overview**

The choice of research methodology must be consistent with the intent of the research and its philosophical underpinnings. The purpose of this chapter is to describe the research methodology and chosen research methods, and to provide rationale for their choice in relation to the goals of the study. I also share here the personal motivation behind the choice of the narrative approaches used in this study. I address the ontological and epistemological considerations in choosing this methodology.

### **The Statement of the Problem**

The research problem was stated as follows: What were the experiences and stories of nurse leaders who successfully provided leadership to increase diversity and inclusion within the profession? The research questions that guided the study explored the participants' stories related to the study's conceptual underpinnings-- diversity, professional closure, and leadership—and their interrelationships. These questions explored the participants' stories with respect to the development of their conceptions of diversity, professional closure, and leadership. Further discussion linking the interview questions to the research problem is included in the *Research Methods* discussion in this chapter.

### **Stories as Research: Personal Reflections on the Choice of Methodology**

In choosing to explore the stories of nurse leaders who successfully increased the participation of Aboriginal, immigrant and visible minority peoples in the nursing profession, I opted to use a modified narrative inquiry approach. I explore the theoretical considerations with respect to narrative inquiry and its choice as a methodology later in this chapter, but I chose to situate myself as researcher in this choice prior to that discussion.

Stories have played a significant part in my personal and professional development, rooted in my childhood experiences, and supported by my experiences as a nurse and nurse educator. In my youth, as the youngest in a Manitoba farm family of four children, I was surrounded by stories. My mother, who was a teacher by profession, valued language and reading and was insistent that we learn to read early and speak well. My earliest memories were of her reading to my sister and me at bedtime, and

encouraging us to talk about what we heard in the stories. Bible stories, tales of animal adventures, stories about families, and chronicles of pioneer life were all part of her repertoire, stories that were so much a part of the pleasant memories of my childhood that I read them to my own children, and have copies secreted away, awaiting the day that I have grandchildren.

Growing up on a farm, with frequent visits from friends and relatives, summer play was outside until dark, at which time we all came in to our small farm home and crowded around the dining room table. The proverbial sandwiches or fruit bread and cheese appeared, followed by cookies or cake. While the plates made their incessant trips around the table and were surreptitiously replenished from the kitchen by my ever-in-motion mother, or my sister and myself as we got older, stories were told by the adults—stories of the “dirty thirties,” hardship, practical jokes on siblings and friends, farm life, community life, war, politics, and family. These stories were almost exclusively about relationships, and they were most often very funny! My father, a big, usually quiet spoken farmer, regaled the table crowd with story after story. When he finished a story he would sit quietly, with a shy grin on his face, a glint in his eye, and perhaps a quiet chuckle under his breath, as the rest of the crowd howled with laughter.

It was through these stories that I developed the values that have guided me throughout my life. Values of hard work, service to others, commitment to family, the need to take care of the land that supported us, the importance of being treated fairly and of fair treatment for others, the significance of sticking up for yourself, your family, your neighbors and those who needed your help, survival through cooperation, and the importance of a sense of perspective and, above all, a sense of humor—all of these came from those sessions around the dining room table.

Later, during the beginning days of my nursing career, I set out to establish therapeutic relationships with the patients who were the center of my professional life. These relationships were forged around the stories they told—stories of their current illnesses and ailments, stories of how they experienced these life-altering events, stories of the impact on their lives, their work, their families and their relationships. Many of these stories are still with me today, and serve as constant reminders of the enormity of

the impact of illness, and the ensuing interaction with the health care system, experienced during health crises.

As a nurse educator for over 30 years, I have relied on stories to bring nursing practice realities into the classroom setting, and to make “big picture” connections for students when I go with them into the practice setting. Stories allow students to test drive their new found theoretical knowledge against real life cases. Stories spur them to work through their own values and beliefs in relation to the ethical dilemmas of nursing practice and health care delivery. These stories are my most powerful tools in my role as a nurse educator.

I did not retire my use of stories in my role as an administrator in nursing education for fifteen years, in frontline, middle management and senior management positions. Stories played a key role in accomplishing the tasks at hand. While my budget submissions and contributions to the organizational business plan were replete with the necessary numbers and statistical analyses, they were always accompanied by stories that illustrated the consequences of failed funding in areas where I was attempting to leverage increases. Stories were especially important and effective when budget submissions and strategic planning documents went directly at politicians, instead of chief financial officers and budget analysts. Politicians were influenced daily by the stories of their constituents, and often immediately grasped the significance of the story being told, despite its reliance on an “n of 1”. Stories were important strategic tools in my administrative tool bag. Thus, it was natural that I would gravitate toward a methodology that privileged such a powerful aspect of my personal and professional life.

### **Narrative Inquiry as Methodology**

Narrative inquiry uses the collection of stories as the source of its data (Duffy, 2007). Stories are the tools with which individuals build a sense of their experience in the world, and the vehicles by which they share that sense with others (Kirkham, Van Hofwegen, & Harwood, 2005). Marshall and Rossman (2006) maintained that stories “assume a complex interaction between the individual’s understanding of his or her world and that world itself. They are, therefore, uniquely suited to depicting and making theoretical sense of the socialization of a person into a cultural milieu” (p. 115). Narrative

inquiry “seeks to understand sociological questions about groups, communities and contexts through individuals’ lived experiences” (Marshall & Rossman, 2006, p. 118). Thus one can draw understanding of a social situation and social practices through the stories of individuals.

The use of qualitative methodologies in the study of leadership is a relatively recent phenomenon. Bryman (2004) indicated that the first qualitative study in the leadership field did not appear until 1988. Qualitative approaches were preferable for this study because of the “fruitfulness and often greater understanding that we can derive from qualitative methods” (Berg, 2007, p.2). According to Berg, qualitative approaches led to meanings, concepts, definitions, characteristics, metaphors, descriptions and symbols, rather than simply quantifying experience. Qualitative researchers were interested in the essence and ambience of that studied, rather than an assumption of certainty (Berg, 2007; Thorne, Kirkham & MacDonald-Eames, 2007). Despite its late arrival to the study of leadership, there is evidence of increasing qualitative methodological diversity in the field (Bryman, 2004). The choice of narrative inquiry for this study supports that methodological diversity.

In describing the qualitative approaches used in this study, it was important to address the relationship between experience, narrative and story. Prominent narrative inquiry researchers Clandinin and Connelly (2000) articulated the relationship between experience and story. Unlike some scholars, they used the term story and narrative interchangeably, but in doing so, they did not equate narrative with narration, or the simple chronicling of action. For Clandinin and Connelly, creating stories was a way of making sense from experience, or perhaps more accurately, from our accounts of experience. To Clandinin and Connelly, storytelling was one way of coming to understand experience, and of sharing the meaning of that experience with others.

Narrative has its origins in our interest in experience. With narrative as our vantage point, we have a point of reference, a life and a ground to stand on for imagining what experience is and for imagining how it might be studied and represented....In this view, experience is the stories people live. People live stories, and in the telling of these stories, reaffirm them, modify them, and create new ones. Stories lived and told educate the self and others. (Clandinin & Connelly, 2000, p. xxvi)

For the purposes of this study, the terms narrative and story were used interchangeably, with recognition that what was sought from participants was much more than the simple recounting of experiences, but storied understanding of the personal meaning of those experiences at the time of the telling (Tierney, 2002).

Chase (2005) made a case for the importance of narrative, not only at the level of the individual per se, but as a means to explain the “interactive process between the individual and his or her socioeconomic environment” (2005, p. 653). She saw the value of narratives in the development of themes, first within individual narratives, and then across narratives. She quoted early sociologists Thomas and Znaniecki, from their 1918 work *The Polish Peasant*:

A social institution can be fully understood only if we do not limit ourselves to the abstract study of its formal organization, but analyze the way in which it appears in the personal experience of various members of the group and follow the influence it has upon their lives. (p. 1833)

Connelly and Clandinin (1999) noted that narrative inquiry was more than telling a story. It was essential to move beyond the story through analysis to the social level. They concluded “It is not enough to write a narrative; the author needs to understand the meanings of the narrative and its significance for others and for social issues” (p. 138). Chase (2005) indicated that narrative lends itself particularly well to studies of changes within a society and societal groups.

According to Frost and Cliff (2004), narrative approaches are gaining ground in nursing research, a fact that they attributed to the “strong oral traditions in nursing, where information and knowledge are transmitted in conversation”(p.172). They noted that nursing is “arguably concerned with operating in the client’s context, while the doctor diagnoses and treats within the medical context” (p.173). This view of the value of storytelling in nursing in creating meaning is supported by Bailey and Tilley (2002). As I have previously indicated, this oral tradition in nursing played a large role in my own career.

The narrative inquiry method chosen for this study best resembled that described by Polkinghorne (1995) as “analysis of narratives” rather than “narrative analysis.” The method used here constructed narratives for each of the participants following in-depth



semi-structured interviews, and analyzed these narratives from a critical perspective to create descriptions of themes that occurred within stories, and across them. This differs from “narrative analysis” which uses the storied data from interviews to construct new stories and plot-lines (Polkinghorne, 1995).

I described the method used as a modified narrative inquiry approach because my research did not correspond precisely with some of the prominent definitions of narrative inquiry. Creswell (2007) advocated narrative inquiry methods for small numbers of participants, often just one. I involved five participants in this study. Clandinin and Connelly (1999) advocated much more participant observation and researcher immersion over a longer period of time than was done in this study. Such modification is supported in the literature. For example, Chase (2005) noted that narrative approaches may be *eclectic* in nature:

Contemporary narrative inquiry can be characterized as an amalgam of interdisciplinary analytic lenses, diverse disciplinary approaches, and both traditional and innovative methods—all revolving around an interest in biographical particulars as narrated by the one who lives them. (p. 651)

The sampling method for choosing participants was a purposeful one, which also employed snowballing techniques (described more fully in the *Research Methods* section of the chapter). Narrative inquiry methods require the careful selection of participants who have stories to tell in relation to the focus of the research (Creswell, 2007). The choice of participants is often a political one, according to Creswell, one that brings attention to the study or that brings in participants who have affected or been affected by the social situation under study. Such was the case in this study, where the participants represented a broad range of nurse leadership experiences and brought widely divergent stories which ultimately generated common themes.

### **Is Narrative Inquiry Methodology Consistent with Critical Theory Approaches?**

Critical social theory is the meta-theoretical lens through which this study has been viewed. The methodological question that arose from this choice of approach was this: How would I reconcile the use of a research method that focused on the stories and experiences of *individuals*, when the focus of critical social theory is at the level of power imbalances and societal structures at a *collective* level?

There was support in the literature for such use of narrative inquiry in the study of social change (Chase, 2005; Marshall & Rossman, 2006). Kirkham and Anderson (2002) saw the consistency in using a method focused at the level of individuals in conjunction with a critical social theoretical approach. Identifying the dichotomy between self / society, and local/ global as basic tensions within critical social theory, they advocated for research methods that link the particular and the general. They sought methods that brought about understanding of everyday experience, and linked that understanding to the social structures and systems that create inequity in society.

In order to explore the appropriateness of narrative inquiry as critical inquiry, I examined the roots of narrative inquiry as a methodology. Clandinin and Rosiek (2007) situated the origins of narrative inquiry in the *interpretivist* paradigm. Burrell and Morgan (1985) described the interpretivist paradigm as one

...informed by a concern to understand the world as it is, to understand the fundamental nature of the social world at the level of subjective experience. It seeks explanation within the realm of individual consciousness and subjectivity, within the frame of reference of the participant as opposed to the observer of the action....It sees the social world as an emergent social process which is created by the individuals concerned. (p.28)

By contrast, Burrell and Morgan located critical social theoretical approaches in the *radical humanist* paradigm. Unlike the interpretivist paradigm, radical humanism is “committed to a view of society which emphasizes the importance of overthrowing or transcending the limitations of existing social arrangements” (p. 32). Radical humanism moves beyond description of the world as it is, and advocates identifying and transcending current hegemonic practices that limit the potential and participation of oppressed groups.

While the literature revealed a disconnection between the interpretivist and radical humanist paradigms with respect to their views on the nature of society, there was consistency in their view of reality as a socially negotiated process. While the interpretivist saw this negotiation in relation to the individual in his or her social situation, the radical humanist critically analyzed the individual’s negotiated view of

reality against social structures and practices that perpetuated inequity, power imbalance and injustice.

Although narrative inquiry was not rooted in a radical humanist tradition, Clandinin and Rosiek (2007) believed that, with proper respect and attention to the narratives of the individuals involved, narrative inquiry could serve effectively as a methodology that contributed to making visible, and contesting, oppressive conditions. Key to the success of fusing narrative inquiry methods with critical approaches was a central commitment on the part of the researcher to social justice (Clandinin & Rosiek, 2007).

Throughout the construction and implementation of this study, I supported and promoted a critical theoretical approach to the concepts of leadership, diversity and professional closure. I was, and continue to be, committed to social change and challenging the power imbalances and exclusions that exist in our social institutions and practices. I chose modified narrative inquiry as a method that linked those social institutions and practices to the actions and stories of individuals who have successfully contested these borders in current social practice. This methodology linked the everyday experiences of those who live with and work for social justice with a critical view of society and its institutions and the impact of these institutions on achieving social justice.

Using Burrell and Morgan's description of the radical humanist paradigm I reconciled their idealist view of reality as a social construction with the intents of narrative inquiry in unearthing the social constructions of individual realities. Narrative inquiry allowed for the examination of individual experience from a political perspective, a lens that "attends to the micropolitics and macrodynamics of power" (Kirkham & Anderson, 2002, p.10). Using modified narrative inquiry as a methodology, my goal was to unearth the synergies linking the personal stories of change agents to the changes they seek.

### ***Description of the Research Methods***

As previously noted, the study was a qualitative one, using adapted narrative inquiry approaches to gather, analyze, and report the data. The study involved five participants who were formal or informal nurse leaders in education, practice or

profession policymaking, and who were involved in increasing the participation of Aboriginals, immigrants or visible minorities in the profession. I identified participants for the study using purposive sampling techniques. I initially elicited suggested names of suitable participants during conversations with formal nurse leaders, including the past president of the Canadian Nurses Association, the current president of the Canadian Association of Schools of Nursing, and the executive director of the Saskatchewan Registered Nurses Association. These formal nurse leaders were asked to identify nurse leaders who, in their view, championed diversity in nursing, and provided leadership to successfully increase the participation in nursing of Aboriginals, immigrants and members of visible minorities. These formal nursing leaders were selected to provide participant names based on their long history with the nursing profession, and their knowledge of nursing issues from a broad perspective. By virtue of my history in the profession, these formal leaders were known to me personally. I was aware of both their excellent qualifications, and their likely willingness to provide me with names of nurses who were leaders in the profession, either formally or informally, and who were champions of diversity within the profession.

Once the names of potential participants were determined in conversation with these formal leaders, the formal leaders were then asked to contact the potential participants by email to invite them to participate in the study. The letter requesting the assistance of the formal nurse leaders in contacting the selected participants is included in Appendix B. The formal nurse leaders then passed on, by email, my letter of invitation to the potential participants (see Appendix B). Potential participants were asked in the letter of invitation to contact me by email or telephone if they were willing to participate in the study.

Initially, three participants were selected from the names suggested by the formal nurse leaders. The participants were selected based on their work with one or more of the target diversity groups—Aboriginals, immigrants, and visible minority group members. In identifying participants, there was a modest attempt to have representation from different aspects of nursing, including nursing education, nursing practice, and

professional policymaking bodies. Participants who agreed to participate were asked to sign and return to me via email or mail the consent form contained in Appendix B.

Once the initial three participants were selected and interviewed, I used snowball sampling techniques to get the names of the next participants. Snowballing is a purposive sampling technique which allows the initial participants to enhance the study through direction to information-rich, strong interview subjects (Merriam, 1998). Mason (2002) described such purposive sampling techniques as allowing for a sample which is meaningful and which allows the researcher to test a theory or argument, or build knowledge to allow for further research.

At the conclusion of the first round interviews, the initial participants were asked to provide names of other potential participants. If they agreed to assist me in identifying additional participants, each of the first round participants received a letter of request for assistance, (Appendix B), and was asked to forward the letter of invitation to participate in the study (Appendix B) to their identified potential participant. As was done with the first round participants, the second round participants were asked to contact the researcher by email or telephone to determine if they were interested in participating in the study. Letters of invitation were then sent to these participants in the same manner as with the initial group of participants, and consent was attained before the interviews took place, as with the first stage participants. In the second round of interviewing, three potential participants were initially contacted. One declined for health reasons. Another name was provided to replace the individual who was unable to participate, contact was made, and consent attained. One participant eventually withdrew from the study (The implications of this withdrawal are discussed later in this chapter) Table 3.1 introduces the five participants and includes a brief description of each of them.

*Table 3.1 Description of Study Participants*

<b>Participant</b>	<b>Background</b>	<b>Area of Nursing Leadership</b>
Mark	Canadian born and educated, White male	Nursing education, policy consultant
John	Canadian born and educated, White male	Acute care practice leader, policy consultant
Katherine	Canadian born and educated, White female	Nursing education
Madonna	Born on a Caribbean island, educated in nursing in Canada, self described Black female	Community development leadership
Mariam	Born in Middle East, educated in nursing in Middle East, visible minority	Nursing leadership in a hospital setting, policy consultant

Of the six participants originally participating in the study, two, including Mariam and Val, a participant who ultimately withdrew, were completely unknown to me. I had been introduced at face-to-face national nursing meetings with two others (John and Madonna), but had no further contact with them other than the introduction. Two of the participants, Mark and Katherine were known slightly to me on a professional basis. We had attended national meetings and had spoken informally with each other on several occasions. Because I did not know any of these people well on a personal level, the establishment of relationships occurred during the interviews themselves, although I benefitted vicariously from my own personal relationships with the national nurse leaders who suggested my first round participants, and in the second round from the relationships between the first round participants and their suggested participants in the second round. As one participant put it, “XXX asked me to talk to you for this study, and I would do anything for her, so here I am.” The establishment of relationships in telephone

interviews is further discussed in the section of Chapter Three that addresses the withdrawal of Val, a key study participant (p. 132-133).

Participation involved two semi-structured in-depth interviews of one to two hours each with each participant, directed at eliciting stories of leadership in relation to increasing the recruitment, inclusion, and retention of members of the targeted diverse groups in nursing. Four of the five participants were interviewed by phone, and one was interviewed by video link-up. Although I offered to arrange to travel to meet with the participants in person, all declined, stated that they felt comfortable with their chosen interview method (phone, video link). Interviews occurred in a private location, of the participant's choosing. One of the participants opted to be interviewed at home, four in their places of work. The focus of the first interview was largely on the participants' views, conceptions and stories related to diversity, inclusion, exclusion and difference in the nursing profession. The second interview addressed the leaders' conceptions of and stories about leadership in general, and specifically with respect to promoting diversity within the profession. The purpose of arranging the interviews in two sittings was to allow the second interview to provide an opportunity for the participant to review and clarify any issues from the previous interview, prior to proceeding on with the second interview. Munhall (2007) recommended a second interview to provide an opportunity for adding details, clarifying, and addressing themes that arose in the first interview.

Interviews were semi-structured, tailored to the specific interviewee, based on their experiences. Attention was paid to the participant's individual comfort. I asked each participant half way through the allotted interview time if a break was required. I ensured that each participant had an opportunity to ask any questions or make comments about the process as it unfolded. Data collection also included articles and website information written by and about the participants, and the interviewer's notes.

The interview guide used for the interviews is included in Appendix B. Munhall (2007) stressed that some of the key pitfalls in narrative interviewing included not seeking clarity and specificity when a participant described experiences in ambiguous ways, and not pursuing "richer, thicker descriptions and meanings when stories seem clichéd or structured to meet the interviewer's needs (Duffy, 2007, p. 412). The interview

questions used were considered a starting point for the discussion, with the intent to encourage expansion on the questions and exploration of themes that emerged within the stories of the participant. The relationship between the research problem, research questions, and the interview questions is outlined in Appendix A.

The tapes of the interviews were professionally transcribed. Pseudonyms were assigned when referring to the participants within the study, and for any groups and organizations with which they were affiliated. Participants were given an opportunity to choose alternate names if they preferred to do so. One participant (Madonna) chose her own pseudonym. The rest of the participants opted to keep the pseudonym I had selected. The pseudonyms were used in reporting of the data.

Following transcription, I provided the transcript of the interview to each participant for their feedback. At each step of the process, participants had opportunity to ask questions, make comments and change, clarify or omit any aspects of the transcript. Email consent was attained for release of audio tapes of the interviews (Consent form included in Appendix B).

Because the data were collected from a small population of nursing leaders working in a small community of individuals dedicated to enhancing diversity within the profession, I was not able to guarantee anonymity. Participants were alerted to this fact prior to providing consent. However, I assured the participants that I would make every effort to protect their identity. I agreed to share the constructed stories with each of them prior to including them in the final dissertation document. Participants were told that they could withdraw from the study at any time, with withdrawal of any data gathered to that point. A description of the data analysis techniques is included at the end of the following section of the chapter.

### ***Data Analysis and Interpretation***

Many methods exist for analyzing, interpreting and representing the research data. Munhall (2007) and Mishler (1995) described a system of structural analysis developed by Labov in the early 1970's, whereby narrative data were examined line by line, for the following structural elements: abstract, orientation, complication, evaluation, result, and coda. The abstract provided an overview and summary of the story. The orientation



oriented the reader to character, time and place. The complication detailed the critical events. The evaluation provided the meaning and implications. The result outlined the resolution of the story. The coda described how the storyteller related the events of the story to the present.

Mishler (1995) advocated a functional framework for analysis of narratives, using the following categories; persons; cultures, social processes, and institutions.

Creswell (2007) proposed analyzing narratives for key elements, including time, place, plot and scene. Story lines can be placed in chronological order. The plot may be analyzed for the presence of *epiphanies*, points at which the plot changes dramatically. Clandinin and Connelly's analysis (2000) included three dimensional *narrative inquiry space*, involving the interaction (personal and social), the continuity (past, present, and future), and the situation (the place).

Regardless of the framework used to analyze the field texts, analysis of narratives resulted in a *re-storying* of the narrative (Chase, 2005; Creswell, 2007). Creswell noted that re-storying involved rewriting the narrative using the chosen analytical framework and identifying the themes that arose during analysis. The data analysis in narrative inquiry involved the story, and the themes emerging from it (Creswell, 2007).

Connelly and Clandinin (1999) saw voice and signature coming together in the writing of the research text. This writing was aimed at the audience. They articulated four approaches that could be used in establishing a relationship with the audience: descriptive, expository, argumentative and narrative approaches (Connelly & Clandinin, 1999). Descriptive texts simply described, while expository research texts intended to explain. Argumentative texts were used to influence policy and practice. Narrative texts simply served to tell the story. The texts generated in this study were expository, structured around themes that explained the structural, social and political aspects emerging from the stories.

The stories generated in this study were constructed using the participants' own words. These words were woven into the story form seen in Chapter Four. Participants' stories were presented, using pseudonyms, in the order in which they were interviewed. In constructing the participant narratives I used the participants' words verbatim in most

instances, but I changed or omitted place, organization, and personal names in an effort to maintain anonymity. When quoting participants directly, I used an italicized font, in order to differentiate the participants' own words from text constructed by me to set context for particular stories, transition to other stories, and to situate the particular story of the participant within the framework of the study. Stories were constructed using the three overarching concepts (diversity, leadership and professional closure) of the study as a template. To construct the stories, I selected particular transcript sections, restructured and reordered them, and wove them together into coherent narratives that did not correspond directly to the actual transcripts. For example, early influences in their lives were presented in chronological fashion in the study narratives, even though the discussion of these early influences often did not occur in chronological fashion during the interviews. I also removed some speech interruptions, corrected minor grammar errors, and changed tenses in some instances to improve the readability of some sections. Each of the narratives was shared with the participant to ensure that it fairly represented the participant's intentions as expressed during the interview process. Each of the narratives that appeared in the study was approved for inclusion by the narrator.

### ***Researcher Voice***

Chase (2005) indicated that narrative researchers use a variety of methods for listening to the stories, both during the interview and while interpreting it.

Narrative researchers listen to the narrator's voices—to the subject positions, interpretive practices, ambiguities, and complexities—within each narrator's story. This process usually includes attention to the “narrative linkages” that a storyteller develops between the biographical particulars of his or her life, on the one hand, and the resources and constraints in his or her environment for self and reality construction, on the other. (p. 663)

Marshall and Rossman (2006) asserted that narrative research allows not only the research participant's voice to be heard, but, as a collaborative process, also allows for the voice of the researcher. Chase (2005) addressed the way in which narrative researchers use their voices in interpreting and representing the narrator's voice. She proposed a typology of three voices used by researchers in the analysis of narratives: the

researcher's authoritative voice; the researcher's supportive voice; and the researcher's interactive voice.

In the *authoritative* voice, researchers "connect or intermingle their voices with narrator's voices" (Chase, 2005, p. 664). The participant's story is told in sets or blocks, interspersed with analytical commentary by the researcher. Chase, while acknowledging potential pitfalls in this approach, indicated:

By writing with an authoritative voice, these researchers are vulnerable to the criticism that they "privilege the analyst's listening ear" at the narrator's expense...After all, as narrators work to make sense of their experiences through narration, they do not talk about "the selves we live by," "identity work", nonunitary subjectivities," 'discursive constraints,' or 'hegemonic discourses.'" Nor do researchers talk this way in *their* everyday lives. But I prefer...to understand these researchers as making visible and audible taken-for-granted practices, processes, and structural and cultural features of our everyday social worlds. (p.664)

In speaking with authority in relation to the narrator's story, the researcher speaks "differently from, but not disrespectfully of the narrator's voice" (Chase, 2005, p. 664).

The researcher's *supportive* voice is situated at the opposite end of the spectrum from the authoritative voice. This voice "pushes the narrator's voice into the limelight" (Chase, 2005, p. 664). Criticized by some as romanticizing the narrator's voice, Chase preferred to see this approach as aiming "not for establishing authenticity, but rather for creating a self-reflective and respectful distance between the researcher's and narrator's voices"(p.665). It is the use of the supportive voice that ensures that the participant's voice is not only present, but that it is heard.

Connelly and Clandinin (1999) summed up the dichotomy of the authoritative and supportive researcher voices in this way:

Taken to extremes, voice is merely an excuse to vent the researcher's biases. Too strong a voice leads to autocratic subjectivity; too little voice leads to technical objectivity. The dilemma for a researcher is to establish a voice that simultaneously represents participants' lived experience while creating a research text that... speaks to an audience. There are no formal rules for establishing voice and the matter can only be sorted out judicially study by study. (p. 138)

Chase's (2005) third voice is the researcher's *interactive* voice, which displays the intersubjectivity between researcher and narrator: "These researchers examined *their* voices—their subject positions, social locations, interpretations, and personal experiences—through the refracted medium of narrators' voices" (2005, p. 664). The interactive voice allows the researcher and participant to interact through the stories and the researcher's response to them.

In this narrative research, the voice of the researcher was present along side that of the narrator. Contrary to positivist research of the past, this technique injected the researcher's voice, with the effect of undermining the myth of the "invisible omniscient author" (Chase, 2005, p.666). In analyzing and portraying the narratives of the study participants (found in the next chapter), my intent was to privilege each of these voices at various times. In structuring the narratives I relied heavily on the participants' own words, thus privileging the supportive voice. However the stories were structured around a thematic framework that originated in the conceptual framework of the study and emerged as themes within the narratives themselves. In using this framework, I provided some directive commentary to structure the stories, thereby invoking an authoritative voice. It is not until the discussion of the narratives in Chapter Five that I interject my own interactive voice in linking the stories back to the literature and to my own experiences.

### ***Trustworthiness and Credibility in Narrative Inquiry***

Munhall (2007) addressed the issue of "truth" in narrative inquiry. Truth, she indicated, is not the issue, as narratives are not about truth, but about sense-making. What is significant, she indicated, is *coherence*. "Coherence of a narrative account, congruence between a person's point of view and how a person makes sense of things, and how well a story is put together are more important and more interesting to the narrative researcher than the positivist illusion of "truth' is" (p. 404).

Munhall also addressed the issues of trustworthiness and credibility.

Trustworthiness and credibility in narrative research refer to the degree to which the participants have been fully included in the research process and have the opportunity to reflect and comment on their story as retold by the narrative researcher. Both the researcher and the participant then share the responsibility of the re-storying process. In research that emphasizes

collaboration, it seems to me like arrogance to place the entire burden of ensuring the faithfulness of an account on the researcher alone....The researcher's obligation is to provide meaningful opportunities for the participants to review transcripts and the researcher's retold stories. Any changes, concerns or objections simply become part of the story of the research and can be included in the narrative, with review again by the participants. (p. 417)

In this study the opportunities provided to the participants for their feedback were meaningful, and their responses were respected in the construction and revision of the narratives, in keeping with Munhall's suggestions.

### ***Description of Data Analysis Procedures***

Methods of analysis chosen for this study were adapted from the work of Riessman (1993) and Mishler (1995). Riessman's procedures for data analysis included three stages: telling, transcribing, and analyzing. Because I involved five participants, I added a fourth stage, that of comparing. Following data analysis, the process of re-storying occurred.

The telling stage of data analysis actually occurred within the interview itself. Riessman advocated semi-structured interviews as a way of the researcher "giv[ing] up control over the research process and approach[ing] interviews as conversations"(1993, p.56). Riessman saw the interview as part of the process of data analysis in that the interviewer and participant "develop meaning together. Uncertainties are clarified and questions of clarification answered, 'continually inform[ing] the evolving conversation' " (Riessman, 1993, p.56).

The second stage of the data analysis involved transcribing. This stage involved two steps: rough transcription and retranscribing. In accordance with Riessman's recommendations, the initial transcription was considered a rough transcription. With this transcription, I ensured verbatim reproduction of the interview tapes, including words and other features –pauses, utterances, partial words or phrases. Each interview transcription was translated into a rough transcript following the interview. I contracted a professional transcription service, Online and On Time, for this process. Part of the contract for these services involved a legal confidentiality agreement, and a statement guaranteeing security of the data.

I then coded or retranscribed the texts, line by line, identifying structurally the narrative segments and the non-narrative aspects of the transcript. This was done using NVIVO data coding software. The next step in the retranscribing process was to determine how the narratives are organized. I analyzed the phrases in the narratives and categorized them according to Labov's structural framework. Riessman used Labov's (1982) framework to analyze how narratives were organized, the first step, she believed, in interpreting them. Labov's structural framework analyzed each narrative clause with respect to its function: to provide an abstract of the narrative that followed, to orient the listener; to carry the complicating action, to evaluate the meaning of the action, and to resolve the action (Riessman, 1993). Narrative data was coded using NVIVO software, and categorizing the data according to Labov's (1982) structural framework: abstract orientation, complication, evaluation, resolution and coda. Table 3.2 further explains and defines Labov's framework.

**Table 3.2 Labov's Framework for Structural Analysis of Narratives**

<b>Category</b>	<b>Description</b>
Abstract	Abstract: a summary, précis, synopsis, short version. Creates the abstract for what follows (Riessman, 1993).
Orientation	Orients the listener (Riessman, 1993) Introduces time, place, participants, and participants' general behavior before or at the time of the action (Tannen, 1982).
Complication	Carries the complicating action (Riessman, 1993) The mechanism that produces the "narrative backbone" (Tannen, 1982, p. 227)
Evaluation	Evaluates the meaning of the story (Riessman, 1995) Contains statements that are not sequential and do not advance or address the action of the story, but are comments by the narrator on what is going on. (Mischler, 1995, p. 94). Evaluative statements that "reveal the attitude of the narrator towards the narrative by emphasizing the relative importance of some narrative units as compared to others" (Labov & Waletzky (1967, p.37).

Resolution	Resolves the action or conflict (Riessman, 1993)
Coda	Postscript, addendum, afterthought. Brings the narrator and listener back to the present (Sarbin, 1986).

Riesman's third stage in narrative analysis was that of analysis itself. Riessman believed that "analysis cannot easily be distinguished from transcription" (1993, p.60). After analyzing the structure of the narrative in Stage Two, Riessman recommended looking for the meanings encoded in the narrative. I used Mischler's (1995) functional framework for analysis of narratives, employing the following analytical categories: persons, cultures, social processes, and institutions. I reanalyzed each narrative using this coding system, and documented the themes that arose. Table 3.3 further delineates and explains Mischler's functional framework.

**Table 3.3 Mischler's Framework for Functional Analysis of Narratives**

<b>Category</b>	<b>Description</b>
Persons	The individuals involved in the story (Mischler, 1995).
Cultures	"an interpretation of how [stories] express and reflect broader cultural frameworks of meaning" ( Sarbin, 1986, p. 240)
Social processes	The nature and action of the social interaction relayed by the story (Mischler, 1995).
Institutions	The societal roles and organizations represented in the story (Mischler, 1995).

The last step in Riessman's analysis stage was to analyze the narrative with respect to the conceptual framework of the study. The last analysis of the data combed the narratives for relationships to the conceptual framework of the study: diversity, leadership and professional closure. I analyzed the data with respect to themes of diversity, professional closure and leadership, and coded the data, using NVIVO software, in relation to these themes. I then recoded the data in relation to the major

themes, identifying 50 additional subthemes, which I eventually combined into 20 subthemes.

Because I involved five participants, I added a final stage to the process: I cross-referenced and compared the individual coding of the structural, functional and conceptual analyses for all of the participants, documenting common themes and divergences. At the completion of the four stages of data analysis, I then re-storied the narratives, creating a narrative for each of the participants, using their own words. The participant stories, followed by discussion and diagrammatic depiction of my conceptualization that evolved within and across the narratives through the data analysis, was documented in Chapters Four and Five of this dissertation.

I chose a format for re-storying of the narratives based on the methods used in the telling of two sets of stories: David Gregory and Cynthia Russell's book *Cancer Stories* (1999), and Michael Angrosino's *On the Bus with Vonnie Lee*, a short story included in Creswell's discussion of narrative inquiry (2007). Angrosino told the story of the participant in a biographical way, but was also present in the story, reflecting on his own experiences and acknowledging that the narrative was his interpretation of the meaning of the story. Gregory accomplished the same thing, but separated his discussion more thoroughly from the story than did Angrosino. The narratives included in Chapter Four are structured in a way that reflects both approaches, but more closely mirrors Gregory's technique of separating author comments from the narrative itself. Through use of such approaches to the re-storying technique, I intended to capture not only the participants' voices, but to acknowledge my own signature or researcher's voice--authoritative, supportive and interactive-- as outlined by Clandinin and Connelly (1999), and the impact of these voices on the process.

After I completed the re-storying process, I addressed issues of trustworthiness and credibility by sharing with the participants my restored narratives. In doing so I ensured that they understood that this narrative was now a collective process including the researcher's voice. Riessman urged the researcher to return the work to the participants for their responses as part of the validation process. The responses of the participants often serve as "a source of theoretical insight" (1993, p.66). However,



Riessman cautioned, “They may not even agree with our interpretations.... In the final analysis the work is ours. We have to take responsibility for its truths” (p.66). Ultimately, accountability for the telling of the story lies with the researcher.

**Reflections on the choice of data analysis techniques.** On reflection at the completion of the study, I found that the choice of Labov’s structural and Mishcler’s functional analysis techniques did not yield the kind of rich results that the thematic analysis produced. While using these two methods of data analysis resulted in a detailed familiarity as a researcher with the structure and function of the narratives, it was the analysis of the narratives with respect to the study’s main concepts --diversity, professional closure and critical leadership--that resulted in the evolution of the subthemes and produced the template used to structure the stories themselves.

### ***Ethical Considerations***

The study proposal received initial ethics approval with the Behavioral Research Board of the University of Saskatchewan on March 20, 2009. The ethics submission is included in Appendix B. (See Appendix C to view the ethics approval certificate, and its renewal certificate).

Ethical considerations in narrative research most frequently occur around the researcher-participant relationship. Clandinin and Connelly, two of the most prominent practitioners of narrative inquiry, indicated that the researcher must acknowledge and address the impact of the researcher’s presence in the process of data collection, analysis and interpretation (1999). They said, of this presence:

Thus, throughout a narrative inquiry the *researcher’s voice* needs to be acknowledged, understood and written into the final research account. Discovering a researcher’s presence in a research text has traditionally been sufficient justification to dismiss the text as inappropriately subjective. But the reverse applies in narrative inquiry: a text written as if the researcher had no autobiographical presence would constitute a deception about the epistemological status of the research. Such a study lacks validity. (p.138)

Narrative research, according to Frost and Cliff (2004) was inherently participative. The researcher does not passively record and feed back the narrator's reality (Marshall & Rossman, p.118). The listener impacts the story with his or her presence. Frost and Cliff indicated that "The storyteller shapes the story to connect with the listener and as such the listener can help to 'author' the story" (2004, p. 174). The nature of this impact on the story and on the storyteller concerns some authors (Connelly & Clandinin, 1999).

Clandinin and Connelly (1994) described the dilemma for the researcher that occurs around this issue, using the metaphor of *signature*, or "being in the text." They use the term signature in reference to the actual written account of the study. The dilemma occurs around how vivid or subtle the signature should be (Potgieter & Smit, 2009). They stated that:

...signature can be too thin because other texts or other theories, rather than the writer, sign the work. Equally, the signature can be too thin because the researcher imagines that the participants and their field texts author the work. In gaining voice and a signature for it, the researcher puts his or her own stamp on the work. (p. 423)

Some of the important ethical questions that arise in narrative research were outlined by Creswell (2007). "Who owns the story? Who can tell it? Who can change it? Whose version is convincing? What happens when narratives compete" (p. 57)? Marshall and Rossman (2007) advocated for *relational responsibility* on the part of the researcher with respect to the participants. The researcher must recognize that the telling of the story prompts change on the part of the teller. They advocated that the researcher must be sensitive, respectful and "fully present to the participant" (Marshall & Rossman, p. 419).

I worked hard to maintain an open, respectful and supportive relationship with these participants throughout our relationship. In several circumstances the participants indicated that the interview process was challenging, upsetting and enlightening. However, my experience with one participant bears closer scrutiny: The experience of Val's story.

***Ethical and Methodological Considerations: The Story of Val***

I recruited “Val” (pseudonym) as a study participant following a recommendation from a participant in my first round of interviews. Val was a nurse leader from Canada’s most rapidly growing Canadian minority group. In order to gauge her interest, the first round participant who suggested her name spoke to her about the study. When Val indicated an interest in the study, and in accordance with the approved ethics protocol of the study, the first round participant forwarded her by email the letter of invitation. Val responded to me via email, indicating her interest and asking if we could speak about the study by phone. I spoke to her in late August, 2009. She indicated that she was very interested in participating. I offered to travel to her location to interview her, but she declined, saying that she preferred a telephone interview. We agreed to continue communicating by email to set up the logistics of the interviews. She subsequently returned the email consent and participated in two two-hour interviews, which were completed by mid September, 2009.

Following the interviews, I provided her with the transcripts, which she reviewed. She returned a release form indicating their accuracy in mid October, 2009. The re-storied narrative that I constructed based on the transcripts was then shared with her in early December, 2009. I indicated at that time that I would follow up with her if I hadn’t heard from her by January 11, 2010 (as I had indicated with the other participants). When I had not received any response from her by the third week in January, I emailed her in follow-up. She responded by email, asking that we discuss the narrative.

We spoke on January 28, at which point she expressed reservations about allowing the story to be included in the study. After discussing some possible changes to the story, she agreed to talk to me again after I had completed them. I forwarded the revised story to her in mid February, and followed up with a phone call, as we had agreed. During that phone call we agreed on a time when I would call her so that we would review the revised narrative together. During the planned phone conversation, in response to questions she had raised in the previous phone call, I was to share with her how her narrative related to the stories of the other participants and how it related to the themes of the research study. She responded positively during this phone discussion, and

agreed to talk with me February 16, 2010. On February 16, I received an email asking that we reschedule the phone conversation until February 19<sup>th</sup>. I agreed to talk with her by phone then. However, on February 18<sup>th</sup> she emailed me, saying that she was withdrawing from the study.

### ***Reflections on the Research Experience with Val***

Val's withdrawal left a significant hole in the study. I no longer had a voice from her specific minority group, a loss that was significant given the importance of the context in which I worked--as a nurse educator in a province with a large, rapidly growing population from this minority group, which was not proportionally represented in the nursing profession. In addition, recruitment and retention into nursing of people from this minority group had been a major focus of my administrative practice for almost half of my nursing education career. But even more important, Val's stories were compelling and related in forceful ways to the themes of this study. The loss of these highly relevant, intense narratives was emotional and painful for me. Her stories had affected me in powerful ways, and I mourned the loss of these stories and their significant messages, both personally and professionally. As a researcher I reflected on the research process and what lead us --researcher and participant-- to this place. This participant had participated willingly and enthusiastically in the initial stages of this process. She had released the transcripts of the interviews to me, indicating that they fairly and accurately represented the interview process. Her enthusiasm began to waiver when the story was re-storied and presented back to her.

Upon reflection, I believe that Val's withdrawal from the study ultimately related to *voice* in the research process. As previously noted, narrative research is a collaborative process (Marshall & Rossman, 2006). Narrative research allows not only for the voice of the participant to be heard, but also allows for the presence the researcher's voice. Chase (2005) spoke of three voices of research: supportive voice, authoritarian voice and interactive voice. The voice of the participant, or Chase's supportive voice, was highly visible in this research process through the reliance on the participants' own words in re-telling the stories.

The telling of the narratives within a framework that emerged during the study, and the insertion of explanatory and connecting blocks of researcher commentary between the participants' stories, served to insert the *authoritative* voice of the researcher into the re-storying process. As Chase noted, the insertion of the authoritative voice of the researcher was intended to lend structure to the narrative in a way that made visible, as previously noted, the "taken-for-granted practices, processes, and structural and cultural features of our everyday social worlds" (Chase, 2005, p.664). In this research process, Chase's *interactive* voices of researcher and participant combined emerged during the analysis of the stories individually, and during the meta-analysis stage comparing all of the stories.

It was at the point of the insertion of the researcher's voice into the process that Val began to hesitate. Riessman (1993) noted that during the process of re-storying, the story becomes a collective endeavor and is no longer the narrator's alone. It was during the process of transitioning from being the storyteller's story to becoming a collaboration that this process broke down.

In reflecting on this process, I observed that not all narrative researchers advocated obtaining the participant's permission to use the final story. Riesman (1993) noted that the researcher and participant may in fact disagree on the interpretation of the final story, and that, ultimately, the story and its telling becomes the responsibility of the researcher. While not requiring the permission of the narrator to use the story, Riesman advocated for the sharing of the final story with the participant. As previously noted in this chapter, she indicated that differences of opinion on the interpretation of the story contributed to *theoretical insight* (Riessman, 1993).

I opted not only to share the constructed narratives with the participants, but to seek their approval before using them. I did this despite the fact that I was not required to do so by the ethics approval process. I did this for two reasons. First, I felt uneasy using a narrative based on a participant's interaction with me if the participant was uncomfortable with what the narrative said, regardless of the "theoretical insights" it might have provided. I felt that it was important that I continue a dialogue with the participant until we could come to an agreement on how the narrative could best be

presented. For example, during an interview, one participant, obviously frustrated, was highly and at times unkindly critical of colleagues for their attitudes toward people of difference. When presented with these verbatim comments in the narrative, the participant indicated a preference that the wording be “toned down.” We negotiated around this issue until we agreed that the gratuitous nature of some of the comments could be removed without detracting from the obvious unhappiness and moral distress of the participant with respect to the views of these colleagues. In this case the participant was willing to negotiate these changes and was satisfied with the result. In Val’s case, she withdrew before this negotiation could take place. While I was not required to by the ethics approval processes surrounding this study, I respected her wishes and withdrew the narrative, because I was not comfortable with refusing to do so.

My decision was also a pragmatic one. The nursing leadership community in Canada is not a large one. The nursing leadership community focusing on diversity and inclusion is even smaller. It was important to me that this research was seen as credible in the nursing leadership community, and in order for that to happen I wanted the research to be, and to be seen to be, truly collaborative. For this reason, I sought feedback and permission from the participants around their narratives, and respected their wishes as expressed in that feedback.

### ***The Story of Val: Lessons Learned***

On reflecting on this experience, I learned several important things about narrative research, and research in general. First, there is risk in choosing a methodology that uses a small number of participants. In a study of 100 people, the loss of one participant is of less consequence. In a methodology such as narrative inquiry, which often relies on one or two participants, the loss of one participant can be catastrophic. While I was left with rich and varied narratives from the five remaining participants, the loss of this one participant was significant.

The withdrawal of this participant was also important in that, while this study was not intended to be a representational one, the sampling technique had been a purposive one, with some modest attempt to balance representation by gender, geography, nursing background and personal experience of difference. The withdrawal of this participant left

the study with an obvious hole: the lack of voice of a leader from this particular minority group.

I learned that the telling of stories is an emotional experience, one that changes the experience of the teller and the listener. All of the study participants indicated that they had spent much time between the first interview and the second, thinking about the stories they had told in the first interviews. Several reported feeling unsettled as a result. Despite Val's willingness to participate initially, the telling of the story obviously had its own personal consequences. For Val, the consequences appeared greater than for the other participants.

I learned that being a researcher is a privilege, and it is a privilege that can easily be abused. Given the emotional nature of the stories that were shared with me by all participants, their willingness to share them was a gift. They shared their stories authentically and willingly, and at some personal risk. In the end, the stories were no longer theirs but were given over to me to be used for my own purposes. Had Val not withdrawn her story, I'm not sure that I would have properly appreciated the sacrifice and commitment that the other participants made in leaving their stories with me. In doing so they trusted that I would treat the stories respectfully and share them in a way that benefitted not only me, but the profession and society in general. This trust made them vulnerable, and it was important that I recognized and respected that vulnerability, and that I did not abuse it for my own gain.

I also learned that her presence in the study, even though temporary, helped to shape the study. Removing her story was not as simple as just deleting it and smoothing out the edges around where it had been. Her story nurtured some of the emerging themes of the study, made these themes evident to me, and contributed significantly to the development of the framework that I eventually used as a template for the telling of the stories. Her story shaped the way in which I viewed the stories of the other participants. While the removal of the story left a hole, its presence, even on an interim basis, strengthened the study and moved it in directions that it might not otherwise have gone. Her presence, while transitory, left its mark. It gave added strength and dimension to the work. For this, I am grateful.

In reflecting on Val's withdrawal from the study, I wondered whether there was anything that I could have done differently. Perhaps in the future I would choose in-person interviews, especially for the second interview if the first interview was emotional in nature. An in-person interview could possibly have developed a stronger bond of trust between researcher and participant, although prior to the sharing of the story in this situation I had not detected any evidence of lack of trust on the Val's part. In the end, there was no indication that she withdrew because of lack of trust.

While some researchers believe that in-person interviews establish stronger relationships between researcher and participant, and thus might have resulted in a scenario where Val was more invested in the research and therefore less likely to withdraw, others cite the value of the telephone interview in providing the participant with a measure of control (Holt, 2010). This control was afforded Val in that I provided her with a choice of in-person interviews, or telephone interviews. She opted for telephone interviews.

While in-person interviews with Val may have resulted in a situation where she felt less comfortable withdrawing, I am not sure that ultimately this would have been a good thing. While having her remain would have definitely strengthened the study, it may ultimately have done damage to her. While I am immensely saddened at the loss of Val as a study participant, I would have been very uncomfortable with the thought that she remained in the study because she was intimidated by the personal relationship that had formed, and uncomfortable with the possibility of disappointing or challenging me by withdrawing. The anonymity of the telephone interview may have given her the confidence to act on her true feelings. That confidence may not have been there if we had interacted face-to-face. In the end, we will never know how the outcome might have been different if face-to-face interviews had been conducted in this instance. Ultimately, this participant elected not to share her story, and this is perhaps the most important lesson learned as a result of this process. Research is dependent upon appropriately informed and supported participants. The researcher can inform and support, but ultimately the decision to participate belongs to the individual.



### Summary

This chapter described the chosen research methodology of the study. It reconciled the choice of an interpretive methodology (narrative inquiry) which usually addresses the experiences of individuals, with critical approaches, which focus on the collective. The chapter outlined how the study linking the personal stories of the participants with the political and social milieu of their lives—linking the personal with the political, as Chase (2005) advocated. The choice of narrative methods was related to my own powerful personal experiences with stories, starting in my childhood and continuing through my career as a nurse and a nursing education administrator. The process of participant selection was described. The purposive sampling techniques used involved seeking input from well known national nurse leaders who suggested participants. Following this process, I used snowball techniques with the initial participants who had been identified by national nurse leaders to elicit additional participants. The interview process was outlined and a detailed description of narrative analysis using structural, functional and thematic approaches was included. The chapter described the re-storying process, using the participants' own words but reordering, linking and weaving their thoughts into stories formatted through using the emergent themes of the study as a conceptual template. It also explored the ethical and methodological considerations that arose when a participant withdrew from the study.

Through analysis of the stories of the nursing leaders participating in this study I learned about critical leadership and the role of leaders in addressing the social and structural barriers to increasing diversity in nursing. These findings are outlined in the following chapter, which includes the constructed narratives and my analysis of them.

## **CHAPTER 4: STORIES OF LEADERSHIP CREATING A MORE DIVERSE NURSING PROFESSION**

This chapter addresses the research problem: What are the experiences and stories of nurse leaders who have increased diversity and inclusion within the profession through their leadership? The intent of the chapter was to answer the research questions as laid out in Chapter Three: 1. How did these nurse leaders come to their current conceptions of leadership, and what were these conceptions? 2. How did these nurse leaders come to their current conceptions of diversity and inclusion, and what were these conceptions? 3. How might the range and variety of experiences and stories of nurse leaders be described with respect to leadership for diversity and inclusion within the profession and the relevant systems?

The research problem was addressed in the form of constructed narratives for each of the participants. As described in Chapter Three, I constructed narratives for each of the participants, based on selected pieces of dialogue from their interviews, plus my commentary on the dialogue in relation to the themes of the study. The selected pieces of dialogue are included here in block quotation format, in italicized font, in order to easily distinguish them from my commentary, analysis and interaction with the dialogue. They are coded in relation to the location of the participants' words in the recorded transcripts. Codes are based on participants' pseudonyms (Mark – Ma; John – J; Katherine – K; Madonna – Md; Mariam – Mm). They are referenced to the transcript of either the first (1) or second interview (2), followed by the corresponding page number in the relevant transcript. All people, place and organization names were anonymized to protect the participants and those to whom they referred in their stories (with the exception of references to public figures such as authors named etc).

The chapter concludes with a comparison of the themes arising in all of the narratives and their relation to the major concepts of the conceptual framework –critical leadership, diversity, and professional closure—outlined in Chapter Two. A discussion of the findings, including relating the findings to the literature, is reserved for Chapter Five.

### **Mark's Story: A Spark to the Flame or "Its not Just Mix and Stir"**

Mark has been a nurse for over 25 years, and a nurse educator for over 20 years. Currently a faculty member in a western Canadian university, he has occupied both

formal and informal leadership positions in academe. He completed a baccalaureate program at a central Canadian university, and followed it with masters and doctoral degrees in nursing. He was identified by several formal nursing leaders in Canada as a key participant for this study because of his known commitment to and active involvement in increasing the participation of Aboriginal people in nursing, primarily through a focus on increased participation in nursing education.

### ***Diversity and Inclusion***

Mark cited the importance of early experiences in his life in forming his views on diversity and inclusion. Born into a military family in a major city in eastern Canada, Mark lived there with his family until he was five years old when his father was posted to a military base in British Columbia.

*...And I lived there for 13 years.... every two years my friends left, because...their fathers were posted. But we stayed for 13 years... (Ma1-1)*

Being part of a military family that lived on base, a family that did not move on a regular basis as other families did, set him apart from others—created in him a sense of being different. However, Mark described an aspect of his family life that impacted his own experience of difference even more dramatically.

*...Every family is dysfunctional, I think, in some way, shape or form. But my mother had acute, untreated schizophrenia, okay. So I lived in a world that was very treacherous as a child, because she was very unpredictable and she was very, very sick and had auditory and visual hallucinations and I thought that was normal, right....I thought every kid's mother would see the Virgin Mary descending from the heavens....She had delusions of grandeur and...she would write her visions down, I'd walk those over to the post office and send them to the Pope...I had to start taking on a parental role as a child, because my mother wasn't-- she was brilliant and she could camouflage and manage her symptoms in the public domain. But privately she was very, very ill. And then my father coped by drinking. So he developed alcoholism... (Ma1-4)*

Mark's early experiences of being different sparked an awareness of difference and a sense of injustice that remained with him today. He would not have entered the profession without the support and encouragement of an influential person in his life—a guidance counselor.

*I stumbled into nursing. I didn't know what I wanted to be and when I was 16, my mother died of breast cancer and it was a terrible experience because the nursing care wasn't very good at all.... That was my exposure to nursing early on and... I didn't think much of it actually. But then I finished high school and I had to figure out, well, what am I going to be when I grow up? And I knew I wanted to either be a teacher or be in social work or be in a helping profession, right.... So my guidance counselor one day suggested I try nursing and I laughed, I thought that was the funniest thing I've ever heard.... But I didn't have really any alternatives in mind, so I said okay. (Ma1-5)*

Mark went into nursing in an effort to make things better—to improve the experiences of others, based on his own less-than-satisfactory experience with nursing and health care. His experience early in his nursing education program definitely added to his awareness that he was different. As a male in an overwhelmingly female profession where men were not common, he did not have to wait long to experience the expectations that nurses were not supposed to be men.

*So I applied to the University of XXX and was admitted and I was looking for the reception for the nursing students there and everyone kept saying, engineering is down the hall. And I said, no, actually I'm looking for nursing and then they'd look at me like I was kind of weird. (Ma1-6)*

Mark's experiences of being seen as Other did not stop at the registration reception.

*Because men in nursing were... reasonably new at that time, I also had to work closely with the dean to get into certain clinical areas. I was denied access from obstetrics, for example. So I had to threaten to go to the Human Rights... and anyway, they worked it out and I did manage to get*

*into labor and delivery. And what I find astounding was, there was a black head nurse, she didn't want men in her unit. So I find that...really fascinating, that this sort of behaviour of the oppressed...nursing is, you know, in that category of oppressed professions, if you will. And so here was this black nurse, who was trying to prevent a male nurse from coming into her unit. (Ma1-6)*

*I will never forget going to [a major national defense hospital] and Captain Greene was the head nurse. She was awful. She was mean spirited and I really questioned whether I would stay in nursing....The very first day I walked in...she said to me... "Good morning, ladies." And I'm standing there, right, and she did it on purpose. But it really bothered me and...I remember having conversations about, well, I'm not sure I'm going to stay in nursing.... (Ma1-8)*

*Furthermore, I discovered that, I was reasonably intelligent and the hospital setting doesn't like intelligent nurses. At least it didn't at that time. So I knew that I would not work in a hospital, because I felt that my abilities, my potential, my intelligence, were not appreciated. They were not valued and I just thought I'm out of here; I'm not going to do this. (Ma1-9)*

But he stayed, and is still there more than 25 years into a nursing career. Mark attributed his decision to stay in the profession to two things: The influence of two phenomenal nurses and role models, and ultimately, the discovery of his passion for the profession. His role models appeared early in his nursing education experience.

*...I met a clinical instructor...Mary Collins....Mary was a black nurse and she-- there's been two clinical instructors that have influenced me in my life. Mary Collins is the first one and Elaine Wartman is the second. Mary Collins taught me how to be caring and compassionate....She allowed me to be caring and compassionate as a male and as a male nurse and...I don't think she really understood the impact that had on me.*

*And then Elaine Wartman... she was inspirational to me, to continue to go on to do my masters and PhD....[With] Mary Collins... the... overarching values and purposes were caring, compassion, loving your patients, respecting them and being competent in your care. Elaine Wartman really helped me to understand the importance of...trying to achieve and working towards excellence in clinical practice and the importance of continuing education. (Ma1-7)*

*So in the end, I stayed. But I remember having a conversation with myself and it was like, Mark, you get your registered nurse status, you're on the same level as these other people who are giving you such a hard time. And I think maybe that too inspired me to go further, to do a masters and a PhD. But also, nobody in my family had that kind of education and I wanted that. I really wanted that. (Ma1-9)*

Mark identified the importance of these role models, who recognized his need for sensitive mentoring into the nursing culture, and addressed his particular needs as a male in learning the nurturing, caring and compassion that were part of that role. Yet while they identified him as being different and having a specific set of learning needs, they did not apply the stereotypes of Captain Greene and the black head nurse in labor and delivery, who felt that he simply did not belong there. Mark was passionate in his praise of these women who inspired him and motivated him to remain in the profession, but he also identified the power of visible role models for members of underrepresented groups in the profession.

*As you know, role models are very, very important and when I went through early on...there was not one male faculty member at the university...It makes a difference and the men in the program were quite different. We were very, very different on all accounts. Age, sexuality, maturity, I mean, there was quite a range. So I didn't really have a peer group. (Ma1-15)*

*...I've had people tell me, male students tell me, that they came to the university where I was previously because there was a male professor in*

*place. And they would hear me on the radio or they'd read about me.  
(Ma1-25)*

While Mark acknowledged that his presence and the presence of other men in nursing education provided role models for men in nursing, he decried the lack of role models for other underrepresented groups within the profession.

*But where I am now, we have no Aboriginal professors and we have no  
Aboriginal clinical instructors and yet we have a program that tries to  
bring in Aboriginal students. So...there's a tension there.... (Ma1-16)*

So we see that Mark experienced difference from an early age. Mark's personal experience with being different influenced his view of diversity. A child from a family that remained on base for 13 years while others around were transferred viewed himself as different. Mark's poignant description of his mother's illness, her isolation, and his role in managing the family as his parents coped with her illness illustrated experiences that set him apart as a child with a life quite different from his friends. And ultimately his choice as a man to enter a female-dominated profession cemented his experience as Other. However, he has overcome this sense of difference to come to embrace the profession as his own.

One needed to interact with Mark for only a very short time before his overwhelming passion for and commitment to the profession radiated. His emotional connection to the profession was striking. For Mark, nursing "just fit."

*So caring, compassion, love, kindness, addressing suffering, providing  
opportunity for the betterment of people's lives in terms of education.  
Those are all congruent with who I am as a person. And so nursing is like  
a glove, it just fits. It just fit beautifully for me. (Ma1-26)*

While Mark's passion and commitment shone through, the deep, almost visceral way in which he connected with the profession also engendered considerable angst and disappointment about the way in which the profession addressed some of its key issues.

*But...I think the profession can do a lot better...around the issues of  
diversity and inclusion, with respect to teaching/learning, with  
establishing these communities of practice that are really much more*

*sophisticated in the understanding of diversity and what that really means.  
(Ma2-49)*

*And dare I suggest that there is a love for nursing and that's why I am  
passionate about it and why I want to accord respect to it, but I also see  
the need for change... (Ma2-6)*

Mark's admonition that the profession "can do a lot better" revealed a distress and angst that continually moved him forward. In moving forward, Mark articulated a clear vision of his desired social order—a social order that stretched the possibilities, and transformed and empowered the experiences of the "Othered."

Mark engaged in dialogue around issues of difference, diversity, "Otherness" and inclusion in the profession. He addressed the importance of attempting to understand the experience of those who were not mainstream in the nursing profession—the current mainstream being, he identified, white, middle class and female. He embraced the importance of understanding the experience of the Other. When asked about his understanding of the concepts of diversity and inclusion he replied

*Those terms mean to me that well, diversity is-- are those people...who  
may look different, be different than sort of the dominant group.....And  
inclusion is attempts to diversify your profession and have your profession  
reflect society as a whole. (Ma1-14)*

While one might assume that Mark's understanding of and commitment to diversity and inclusion in the profession related to his own "Otherness"—being male in a female dominated profession—Mark indicated that, after his early experiences, his gender was not an issue in his nursing career. In fact, it was at times an advantage, as gender gave him a position of unique visibility within the profession from which he could take forth nursing issues such as increasing Aboriginal participation in the nursing profession. Being male actually privileged him in many ways.

*...I think early on, when I was younger, a young man at 19 or 20 in the  
profession; I was a bit of an anomaly. And so yes, I did encounter some  
situations where I felt that my gender was a problem for some people,  
particularly within the clinical sector and so on. But that's all gone now*



*and that's really historical and I feel really fortunate to be part of the profession ...My gender's not an issue, at least I don't perceive it as such with my colleagues or any of the circles that I operate in. (Ma1-15)*

*[Nursing is] a perfect fit and it's a wonderful, wonderful profession....I've been able to exercise some influence on the profession. I think partly I've earned that and partly it's because there...weren't a lot of men in the administrative positions or in academe, right. So that was kind of a timing thing, and right place, right time, kind of thing, as a man...in the profession. (Ma2-48)*

Mark can pinpoint exactly when his passion for issues around diversity and inclusion began. It began when he arrived, as a young nurse, to work for Medical Services Branch in a remote Aboriginal community.

*...It was my immersion experience in the First Nations community, going into that reserve community and looking at the plight of the people in that community and the suffering that I witnessed and the trauma that was there in that community. That's what sparked me to really try to make a difference in terms of Aboriginal nursing. (Ma1-20)*

*I didn't even know about the Aboriginal people. I had no idea of their history. I didn't learn anything about the Aboriginal people as part of my baccalaureate degree, nothing. When I arrived in the community, I'm walking down the gravel road and this Aboriginal man is coming towards me and I'm so green, I'm so naïve... I'm, like, Sunny Jim and I said, "Hello, Mr. Aboriginal man, how are you today?" And...he said, "You know what? F\*\*k you," right. And I thought...what just happened there?...I don't understand what just happened there....That was my first day on the reserve and after two years of living on the reserve, I understand why he told me to do that. But I was so naïve. But working on the reserves, shaped me, right...and that's where...the love and passion for working with the First Nations came from... (Ma1-24)*

So it was not his maleness in a female-dominated profession that drove his commitment to social justice and issues of diversity. It was his experience with the poverty and social disintegration on this northern reserve early in his career that created an understanding of the experience of marginalized people and ultimately sparked his work in the area of diversity in nursing. The nursing experience in a community where he was in the minority opened his eyes to the lives of the “Other.”

Mark’s ability to critically reflect through his stories on the historical nature of marginalization of Aboriginal people and the marginalizing experiences of nursing students—his own, and those of the students he now teaches—clearly illustrated Mark’s ability to critique the social structures of the profession, and his commitment to social justice.

This search for social justice has driven much of Mark’s work in the profession.

*... I worked at an inner city project in XXX City. And the project was, at the time, a drunk tank or the more professional term is the intoxicated person’s detention unit....And I would go in the wagon to the various bars.... Lots of poverty and so on, and I had my eyes opened about the plight of the urban poor. So...in a way...I’ve become a champion for the underprivileged, the poor, people who are very easily discriminated against, whether they’re Aboriginal, whether they’re gay or lesbian.*  
(Ma1-22)

Mark was anxious to talk about ways in which the nursing profession attempted, or failed to attempt to understand the experiences of those from non-traditional backgrounds who were trying to succeed in nursing. He expressed concern over the reluctance of members of the profession to identify and address the unique needs of diverse students. He decried the sentiment of nurse educators that students should all be treated equally—meaning that they should all be treated exactly the same.

*So, a male student, mature, a man in his 40’s, came to me and he said, “Dr. XXX, I have to leave nursing.” I said, “Why?” He said, “There’s way too much intimate care,” and he said, “I just-- I can’t handle it.” And I thought, so...why is this gentleman in his third year of nursing, and*

*he discovers that the care is too intimate for him, he can't manage it and what have we done to help him along that way?...So that's an example, if you treat everybody the same, you're not going to recognize that there may be some unique challenges, unique circumstances, unique opportunities for students or some difficulties they may experience, because of who they are...We lost that student and that was sad....So I think somehow we failed him along the way. (Ma1-26)*

A negative experience in nursing education for an Aboriginal friend caused Mark to really question the intentions of the profession with respect to minority students.

*I think of a story of a colleague of mine, who went to graduate school, she's Aboriginal. The system...destroyed her, right, and it's like...what happened there? Well, she didn't have an advocate. She didn't have somebody who would speak on her behalf or give her the kind of guidance and direction to ensure success in graduate school....So if we're talking about diversity and inclusion, I think there's some opportunities here around graduate education that need to be exercised.... (Ma1-29)*

*...You know what I hear a lot in nursing? They're all the same. They're all the same, men, Aboriginals, they're all the same. They're nursing students and we shouldn't differentiate....But what I have discovered is, actually their life experiences, their nursing career and education, they are different....They have different responsibilities many of our students who are mature, who are men, who are gay....So what I think nursing's done today is this, mix and stir without a critical analysis of what it means to shift your demographic profile as a profession. (Ma1-35)*

*...And further to that, respecting difference, respecting uniqueness is absolutely loud and clear with respect to caring for patients, and yet when we consider nursing students, they're all the same....I think there's a lack of understanding amongst educators as to what really comprises diversity. (Ma2-4)*

In Mark's view, nurse educators teach to a "common denominator". The assumption was that students were "all the same". And while nursing programs might display on websites and in program information a variety of skin tones and genders, the profession still, in fact, assumed a common denominator—the white, middle class female-- and taught from that perspective.

*Here's an example....Men in nursing do struggle, because their touch is sexualized, okay. So do we talk to our male students about that? Do we sit down with our male students and talk to them about...how they have to engage their masculinity within a female-dominated profession? What does that really mean? What does that look like? ...I don't think we have those kinds of conversations....I don't think we have those real conversations that matter. Do we talk about racism, discrimination and prejudice? Either the student's encountering that, or the patient or student are being racist or discriminatory...I think those kinds of conversations and discussions are missing around diversity and inclusivity. (MaI-33)*

*It's this idea of mix and stir, bring them all in, but don't do anything different and we've learned from our Aboriginal students that you have to do things different. You actually have to acknowledge, ontologically, epistemologically, that there's knowledge that these students bring that has to be respected. That their learning style may be different, so you build in opportunities to learn differently for them. Give them choices and that'll foster success....We know that.... So we can't just mix and stir anymore, I think we really need to be smart about how we're working with our students. We need to be active. (MaI-41)*

Understanding that marginalized people had very different lives and very different needs gave rise to his position that our approach of "mix and stir" is not sufficient. Nurse educators must recognize the needs of marginalized students as different and put in place active solutions rather than passive ones to solve the problem.

Mark was committed to increasing diversity in the profession from a broad perspective. Although much of the work for which Mark was known in the profession related to increasing the participation of Aboriginal people in the profession, Mark was clear that he was not simply interested in diversity related to skin color or cultural group. Difference, for him, was much broader than skin tones, culture or ethnicity. It related to being different than the norm. Mark saw the need to commit as a profession to increasing and supporting diversity in existing programs, and developing new programming options such as second degree entry options for those with previous university degrees as a mechanism for increasing and supporting diversity.

*...If we look at the demographic profile of nursing, it still remains a mostly white, middleclass female profession. I think, from my total experiences in nursing...nursing has engaged in passive recruitment....With the exception of Aboriginal initiatives, I think ...we'll present ourselves as diverse, but whoever comes through the door is fine. (Ma1-10)*

*But there's no active recruitment, and furthermore, limited retention strategies. I don't see much of that around diversity and...I think that nursing tends to be somewhat conservative.... (MA1-10)*

*So I think nursing has been... fairly passive about changing its complexion.... (Ma1-11)*

*The other observation I want to say is, the upper echelons of education[are] mostly white...Where are the doctorally prepared Aboriginal students or nurses? ...If we're committed to diversity, we have to look at...what that means in the profession....And so what are we doing to ensure, to encourage, to support graduate level education for diverse populations within the profession?...It seems to me that if you've got a doctorally prepared Aboriginal faculty member, he or she is going to attract masters and doctoral students who are Aboriginal ancestry. It's going to happen, right. (Ma1-29)*

*The other thing I'd say to the nursing leaders is we need to have evidence of students' experiences so that we can look at what's happening and not make assumptions... (Ma1-46)*

*If we look at who's leaving nursing, ...who doesn't complete nursing, I don't have data, but my hypothesis would be men, would be people of colour, would be minority students, maybe older students. It's very interesting...that national nursing and nursing education organizations do not track numbers of men students....Can you imagine if engineering said, well, how many women students? Well, we don't track that. (Ma1-12)*

*How many disabled students are in nursing programs in Canada? I would say ...very, very few. We've had students with mental health issues but if they don't get the kind of support they need they're quickly weeded out. But, I mean, if a student shows up with one hand, oh my God, you can't be a nurse. The whole area of disability or ability in nursing is one that has not been well addressed. (Ma2-6)*

*So that to me is another aspect of diversity, is often we say it's a difference and so it's a problem....The whole language about diversity is imbued with fear; it's imbued with suspicion. Right? (Ma2-7)*

Mark spoke of the fear of change and difference experienced by those in power, but also of the fear experienced by marginalized people in the profession. He spoke of the importance of safety— of creating a safe environment for diverse students. Mark described the need to create a place where students could safely explore their understandings with others and not feel at risk of ridicule and dismissal based on their differentness. He illustrated this point with the following example:

*We've got a full range of people in our classrooms...and I think we need to pay attention to that in terms of their experiences. And if they're having difficult or negative experiences, we need to understand that and adjust things accordingly...I see in the classroom all the time, the Aboriginal students. If you allow students to formulate their own groups, guess who's the last to be chosen? The Aboriginal students. They dislike that process.*

*The students I've spoken to they like it when the professor sets up and puts together groups, because then they're not going to...have the public humiliation, of being chosen last. Because students are cutthroat when it comes to grades and the assumption is, if you've got an Aboriginal student in your group, you're going to get a B or a C....So how does the professor manage the classroom, to ensure that that doesn't happen? (Ma1-38)*

From Mark's perspective, there is a critical need for sweeping change, not only on the front lines of nursing education, but at the leadership level. He lamented the lack of diversity in the leadership of national nursing and nursing education organizations.

*When I go to national meetings, there are just white faces around the table. (Ma1-13)*

*...If you're serious about diversity and inclusivity, we should be seeing some changes...in the decision making bodies around the profession, and I don't see it...So that's in stark contrast to the visible minority faces on the websites, okay, when you start looking behind the scenes.(Ma1-14)*

In summarizing Mark's views on diversity and inclusion in relation to nursing, his key messages included the need to embrace a broad spectrum of difference within the profession, an overwhelming passion for the profession and its ability to make real difference in the lives of marginalized people, his angst and disappointment in the profession's current approach to diversity and inclusion, the importance of role models, and support for addressing the individual needs of students rather than the current "mix and stir" approach utilized by the profession.

### ***Leadership***

After focusing on Mark's views on diversity and inclusion in nursing, our discussions turned to Mark's experiences with leadership. Mark reflected on his leadership experience, indicating that he had formal leadership opportunities early.

*I was head boy in the high school...I don't know what would be analogous to that, but it's like you're the "it" guy... (Ma1-12)*

*I received recognition for leadership and citizenship, I guess throughout my education, you know... (Ma1-3)*

*I was valedictorian for my graduating class in nursing. (Ma1-6)*

But perhaps leadership skills were developed even before these school experiences.

*Okay, well, there's four children and so I really have been a parent since I was about eight years old, trying to manage the family....When I look back on my life, I've always assumed positions...where I have to exercise some kind of leadership, some kind of a quasi-parental role, if you will. (Ma1-4)*

Assuming responsibility as a child led him to seek out responsibility in his nursing career.

*So I think....that has roots in my early childhood, trying to exercise some sense of stability and then really being pushed...in terms of providing some leadership and providing some guidance and input into situations. (Ma1-5)*

*So that's what led me to northern or outpost nursing...I thought yes, I've found my place in nursing....You have to understand that when you work in a nursing station, you are a nurse, pharmacist, counsellor, mechanic, you do home visits, I mean, you do it all, right. So that kind of fit with my pattern in my life, taking on tremendous responsibility...now at the community level. (Ma1-9)*

Leadership developed at an early age, and brought him, through his experiences, to a critical, reflective view of leadership.

### ***Critical Leadership***

Mark's critical reflective approach to leadership revealed a belief that leadership was a privilege, an act of power, a place of competence, and, above all, a way of being that required a well developed sense of humor.

**Leadership as privilege.** Mark talked about the privilege that he has had as a result of his upbringing. Despite its dysfunction, his upbringing provided him with him



many middle class advantages, and such privilege, in many cases, begot privilege. This privilege was exercised in his leadership on issues of importance to him. Privilege gave him visibility to move his issues forward.

*I feel that I've been able to exercise my privilege as an intelligent white, middleclass to upper-middleclass male and my position as a professor and administrator....The great privilege that these positions have offered me...[is that they] have provided me with a voice...to provide opportunities...for people who are living in poverty to get their degrees and so on and become registered nurses. But it's allowed me to exercise my privilege through research, through consulting work, through the creation of position papers and different documents that have weightiness behind them. (Ma1-23)*

**Leadership as power.** There was, for Mark, a significant degree of power in leadership, but he also saw power in the everyday actions of nurses and nurse educators. Power was not positional, but was exercised in relation to others.

*...It's like I tell my students, the power you have over patients is extraordinary and it's the power of everyday living. It's the power of the temperature of the bath. It's the power of when that bath takes place...That is hugely powerful....But the classroom is a whole other community where...the professor, the teacher, has this tremendous power over how diversity and inclusivity is actualized in that community. And ...he or she can exercise that in a way so that student... feels safe. They feel that they are respected. They feel they don't have to go on the defense because of who they are. But that takes skill, that takes maturity as a teacher, and you learn that over time, right. But we need to actively foster that... (Ma1-40)*

In Mark's view, his visibility often took him to additional tables, and allowed him to act on behalf of an issue. He has grown in the role of spokesperson for the issues about which he felt passionate.

*And I did a good job there...I was confident, competent. ...When I'm at the table ...I feel confident and competent and have something to offer... I'm starting to speak up. (Ma1-40)*

**Excellence and expertise in leadership.** Striving for excellence as a practitioner and a leader was important to Mark. He talked of the importance of feeling personally confident in one's role, and being seen to be competent by others.

This confidence was especially handy when dealing with conflict and having the difficult conversations that arose around issues of diversity. He talked about the reluctance of the members of the nursing profession to entertaining discussions about issues of racism, prejudice and discrimination in the classroom, in the clinical setting, between patients and students, students and students, faculty and students.

**Humor as a vital part of leadership.** Mark also identified the importance of a positive perspective and a willingness to see the funny side of things when providing leadership.

*I think that humor is absolutely essential. It's essential to leadership and it's essential to me as a leader. If you can see the absurdity in a situation and reflect on that and laugh at that, that is healing salve... for the spirit, for the soul, and it kind of balances out some of the negative stuff that you have to counter as a leader. So humor is very, very important. And it's self-deprecation, I mean it's all of that. (Ma2-27)*

Mark's story demonstrated the critical reflective aspects of leadership and revealed a sophisticated understanding of the power relationships inherent in leadership, the conflicts that arose when such power relationships were challenged, the privileges that leadership begot, the need for competence and confidence in providing leadership on issues that matter, and the need to maintain a healthy dose of humor in order to get through the day. In addition to his view of leadership as a reflective process, Mark also saw the importance of leadership leading to transformation.

### ***Transformative Leadership***

Essential in achieving societal transformation, in Mark's view, was a passionate vision of what was possible.

**The passion of leadership.** Mark's passion, seen earlier in his commitment to the profession and to social justice, was also evident in his views on leadership.

*And for me, leadership is being fully engaged in the moment. It's investing your life force, your energy, your creativity, and you're bringing that to bear fully and wholeheartedly, right. So you're not-- you're not knitting and crocheting at a board table, you're not...working on an assignment or something during a senate meeting, you are there, and you're present. So leadership is-- I think is all about presence....From my perspective it's being fully engaged in the moment with an idea of some kind of outcome. (Ma2-12)*

*Yes. I like [the] phrase "relational leadership," because...I really think that's important. And that then is a two-way street. It's the fine art of negotiation. It's the fine art of creating a vision or outcome that people say, "Yeah, that's great. Let's go for it." ...I guess that's what I'm trying to say, it's the investment of life force. (Ma2-14)*

**Leadership requires vision.** It was not enough to be passionate, in Mark's eyes. One must also have a clear vision of the possible, a vision that the leader can share with followers in a way that they will embrace. In order to be successful in leading for transformation, the leader must have the vision, and be capable of exciting others in joining to achieve that vision. Passion and vision must be shared in order for transformation to occur, in Mark's eyes.

### ***Educative Leadership***

For Mark, leadership was an educative act. Educative leadership involved recognizing and creating opportunities, and entertaining the potential in everyday situations.

**Recognizing and creating opportunities.** Mark recounted a story that demonstrated in a powerful way his belief in the importance of leaders in any circumstance, at any level, recognizing and creating opportunities.

*Recently I had a student in my class [who had experienced significant challenges getting through the nursing program] ...Was she a little rough*

around the edges? Absolutely. And in the class...I asked the students to present some content in a radically different way. They couldn't use lecture, they had to use something creative and artistic, and this student sang. She sang a song. And I was dumbfounded at the beauty of her voice...and I told her that. I just said, "You know, you have an amazing gift here...you have a beautiful voice." ...I took her under my wing...She was experiencing a lot of difficulties, a lot of challenges in the program because there was kind of a ...full court press against her. But I saw something in her that was, I thought, remarkable. And then you find out that she's had a very difficult life....She's the sole bread earner in her family and she's got children-- a child with disability... and she had experienced a serious disease and so on. And all she really wanted was her degree so that she could be the nurse that she thought she could be....So... I helped her navigate the complexities of coming to terms with her situation. ...About a month ago I received a package in the mail... she's making a CD, and she forwarded to me three songs that she recorded...she wrote this letter and it was the most amazing letter. She thanked me for seeing something in her that...other[s didn't see]; that her ...whole perspective on nursing had changed. She was able to reflect on her limitations but also seek her strengths and she finished her degree....I think if I hadn't demonstrated leadership, she wouldn't have finished, right, and what a loss for us. So I don't know why I'm ...still feeling quite distressed about this but...it's an injustice and I see it all the time. So spark to a flame, seeing the goodness in people, giving people the chance, letting her exercise her capacity as an intelligent person, helping her understand her limitations, that's leadership in action. ...And this is where I think it's leadership at the level of N=1 and sometimes we forget that. And that's what a leader should be doing, I think. Do we have students who fail? Yes. Should they fail? Yes. But I saw something in her and I thought, oh, she can't fail, she can't fail, there's too much at stake here,

*right. And that idea can be applied to a faculty, to a program...that we can't fail, we've got to really do this. (Ma2-31)*

This story poignantly demonstrated Mark's ability to see the possible, to create opportunities in situations where opportunity is not obvious, and to share the potential of those possibilities. This student would in all likelihood have been lost to the profession had Mark not intervened to advocate for her, and to help her "navigate the complexities". Leadership in this situation transformed this student's life and perhaps, in the process, challenged the views of others who had written her off. Mark calls this "leadership at an n of 1." This is societal leadership, one person at a time—a powerful aspect of transformative leadership.

Such leadership takes a personal toll. Mark described the consequences of passionate commitment. He admitted that the desire to recognize and act on opportunities can result in burnout, and great personal cost. There were, he admitted, significant ramifications to always saying yes.

*And I've worked very hard at that.... I mean, I've said yes...when ...the workload was incredible, but I did it because I believe in the cause. (Ma1-19)*

Mark's ability to be passionate about a cause was based in an inherent belief in the goodness of people.

*I always give people the benefit of the doubt...that's how I operate...I always accord them an intelligence, an ability, a capacity. ... I find that we don't always do that, ...we don't always accord a sense of intelligence to people that we're working with... I give them permission to chase their dreams, their goals. I don't try to lock them down. And I see a lot of locking down in the circles that I'm in in terms of education. ...Maybe that's part of the spark to the flame, you know, it's opening up that energy and allowing people to be what they can be. Helping them actualize their potential. So my beliefs and values, I see good in people, I believe that people with encouragement and support can really make things happen in their lives which is good for nursing. (Ma2-26)*

This inherent belief in the goodness of people fueled Mark's passion and vision, and gave him the energy to continue, even when exhaustion and frustration lurked nearby. While Mark professed a positive outlook as a leader, he also expressed moral distress at the lack of support for consideration of possibilities by the profession. He spoke of "locking down"--confining approaches that stood in contrast to the "letting loose" approaches of nurturing and engaging the possible. He painted a picture of a closed system, unwilling to consider alternatives and protecting its existing ways of being. Educative approaches to leadership were essential in attempting to imbue in others the vision of other ways of being.

### ***Ethical Leadership***

It was not enough to have a passionate vision of the possible and a commitment to work for change, in Mark's eyes. It was very important to deal fairly and ethically with colleagues.

**Commitment to listening.** Ethical leadership required listening carefully to colleagues. Without a commitment to listening to colleagues, the leader was likely to end up in places where others simply were not prepared to go.

*... When I was in an administrative position...I wanted to create a second degree option because I saw the value in that enterprise in terms of diversity, inclusivity, addressing the nursing shortage, for a whole bunch of good reasons, but my colleagues were exhausted....This is the message I received, was resistance to the idea. So you know what, we're not going to do that...You know, put the idea on the back burner, and maybe someday, but the timing isn't right. So it's being able to make those decisions that are in the moment, that are right in the moment. So if I had really pushed that, I probably could have got it through, but in fairness to my colleagues, it would have been the wrong thing to do. So there's a moral/ethical principle at play around some of these ideas and if my colleagues are telling me that they're exhausted, that they cannot possibly take on any more I had to listen to that. (Ma2-14)*

Leadership, for Mark, was not positional. It was something that was inherent in one's approach to interaction. It was an intensely moral act.

*...Leadership role is not a one-trick pony. It's not a single context. It's in everything that I do. Everything. So...if I'm engaging students in a class discussion, I exercise a sense of leadership around the dialogue, the discussion. I challenge them and I help them. You know, maybe that's being a good teacher but it's taking risks and it's inviting a dialogue in a safe context so that hopefully the students can appreciate there are other ways of understanding a situation or different paths that people can go down. (Ma2-15)*

In summary, key to Mark's story was his recognition of the importance of the leadership role in creating opportunities. His vivid description of his mentoring and supportive relationship with the nursing student who went on to produce a CD as a result of his belief in her was a testament to the educative and supportive aspects of his leadership. The opportunities created however, were driven by a transformative view of what could be, as well as an ethical commitment to those involved. Underlying all of this was his belief in the inherent goodness of people, and his engagement with the possibilities for them. While Mark was driven in his need to create new, safe, growth-supporting opportunities for diverse students in nursing, he also recognized that he could get out too far ahead of the faculty members with whom he worked. He recognized that dragging them in to transformative experiences when they were at the state of exhaustion actually created an ethical problem. Such conclusions on Mark's part demonstrated an understanding of ethical leadership.

Leadership was for Mark, critical, in that it needed to attend to the power relationships and injustices in society; transformative, in that it was directed at righting those injustices and empowering those who are currently powerless, educative in its engaging others in the possibilities and opportunities, and ethical in its approaches to those around it.

### ***Professional Closure***

In Mark's view, nursing has created barriers to people of diverse backgrounds. He has worked during his career in nursing education to reduce some of these barriers.

*...With baccalaureate as entry to practice, we have, unintentionally perhaps, restricted...who can come in to the program. So don't get me wrong, we need baccalaureate as the standard, absolutely, but what are the implications for diversity? What are the implications for inclusivity? And that's why these bridges are so important with other kinds of nursing. Because I think we do need to have connections for the various nursing professions so that we do get a mix of people. That's another way of coming into nursing....So a lot of Aboriginal people are encouraged to become licensed practical nurses. That really is the option presented to them and I think we need Aboriginal PhD prepared people and we need Aboriginal nurse practitioners and so on. But often what's presented to them, are LPN programs. If you don't have a bridge or a link that's reasonable between those programs, between licensed practical nursing programs-- and baccalaureate programs, then...you shut down a source of diversity within the profession. (Ma1-48)*

*So where are the escalator programs in Canada that take you from a baccalaureate to PhD so that we can...have the next generation of leaders? Where are the opportunities creating innovation and interesting opportunities for our colleagues in the clinical sector to work with them to gain the leadership skills that they need...? (Ma2-45)*

Mark painted a picture of a profession that has, through its lack of willingness to entertain possibilities, perpetuated the existence of barriers that are experienced deeply by marginalized groups. Mark's discussion of the inadvertent consequences of the move to baccalaureate degree as the entry to practice on the profession, in limiting access for students from backgrounds of poverty or backgrounds where university education was not the family tradition, supported the view that professions sometimes create professional closure as an unintended consequence of policy change. His identification of



the need for better bridging programs for practical nurses to achieve their baccalaureate degrees indicated an understanding of the impact of professional closure on specific groups.

### ***Mark's Story: Conclusion***

Concluding with a challenge to the profession, Mark said:

*...I think we're not doing enough as a profession...and ...I don't have all the answers of course, but it's like can't we do better than that? I mean, that's a question I would say: Can't we do better than this? (Ma2-45)*

The themes arising out of Mark's story supported the views of diversity and leadership as outlined in the conceptual model of this study. His views of diversity were broad and not linked to ethnicity or culture. His view of leadership was of a relational practice that required clear vision, passion and ethical approaches. His professional and personal experiences supported the notion that professional closure is a factor in limiting the diversity of the profession.

### ***John's Story: Diversity of Thought, or "When are You Going to Retire?"***

John, a self professed "pink coloured boy" was born in Eastern Canada in the 1950's. His early years in nursing were spend in acute care practice as a staff nurse, educator, clinical nurse specialist and nurse manager, and also included an 18 month stint at a nursing station in a remote northern Aboriginal community. After a Master's degree in nursing, he assumed policy development, advisor and consultant roles of increasing visibility and influence with national and international nursing and health organizations. His name was cited by every national nursing leader consulted as a key player in driving the policy agenda to increase diversity in the nursing profession.

### ***Diversity and Inclusion***

Like Mark, John described the early influences in his life that brought him to where he is today.

*...I spent...most of my life in [a large English speaking city in central Canada]. I was the oldest child, so I probably suffer from the desperate need for control, and overachievement. ....My dad says when I was three years old, that the neighbors would dump their other children on our front*

*lawn because they knew that I would watch out over them. So there was something maybe innate in the desire-- I was going to say to care, others would say to control, to monitor surroundings. (J1-1)*

*I also had a grandmother who was a director of nursing and dragged us around the hospital when we were little kids. And I remember being quite fascinated by all the closed doors and I decided quite early on that I wanted to be a surgeon. And that was, in fact, my plan for most of my life....There was something about the hospital that fascinated me. I had no interest in nursing at all, I just was interested in the sights and smells and...what people were doing walking up and down those halls... (J1-1)*

Responding to a question about how nursing became his choice, rather than medicine, John explained:

*That was an interesting day because it happened very quickly....At the time, I was about 18 or 19....The head nurse in the emergency department at a local hospital ...offered to get me in as an orderly....The first day I was there watching them I realized I'd made a terrible mistake....I had no interest in what the doctors were doing at all and I was fascinated by the nurses and the way they talked, you know...how emerg nurses are.*

*They're kind of lippy and mouthy and strong and probably it was a good place for me to see nursing for the first time. Because that appealed maybe to me as a male, I don't know. But whatever happened that day, I never really pursued thoughts of medicine seriously again. Then later in that summer, I worked on a surgical unit....I just thought it was fascinating and I loved how people interacted with patients and each other and the kind of team thing. And I fell in love with the idea of it and still feel that way 30 years later. So medicine I did not miss and I never regretted that choice. (J1-1)*

John's first attraction to nursing was based on the actions of strong, capable, intelligent, assertive women. It is not surprising then that these attributes continue to be what he holds dear when talking about the profession today.

And how did he come to his interest in diversity?

*Well, at the risk of sounding like...we're both going to need insulin when this is finished, I think there was, from the time we were kids in our family, a belief instilled in us that you should do something in your life that benefits other people and doesn't just sort of glorify yourself. (J1-10)*

John recounted his first lesson about diversity and inclusion.

*...When I was young, probably seven or eight, I made a comment about someone's race....I probably used a derogatory term or something...that kids use when they don't know....I remember we were in the parking lot coming out of church and my mother, who was this nice little Anglican woman... took hold of the front of my shirt and...pulled me up to her face and terrified me with the look on her and said something like, "The accident of your birth put you here. It makes you no better than any fly that's flying around this place and certainly no better than any other human being" and basically, "I'll take you out if I ever hear any language like that again." And it stuck with me, I mean, here we are talking about it [over 40 years later]. I never forgot that and yet I did watch as I grew up how frightened [my parents] seemed to be of anyone who wasn't a Protestant Caucasian. (J1-13)*

*I grew up in a fairly white environment... and then I plunked myself into a high school in XXX [another central Canadian city], where suddenly I saw quite a few people from different backgrounds because of the part of the town that the school was in. Saw them all kind of walking down the same corridors and getting along and I'm of an age where a lot of what we saw of black people, was them on TV being hosed by police, right? Because it was that time...my early memories are of Malcolm X and Americans, scary images of TV of black folks having dogs turned on them and so on and thinking, what in the hell is going on there and not understanding it....But also not having much experience with people of colour. And living in a home where it was strongly valued that you should*

*embrace everybody. But my parents didn't always practice that, because they lived in a very white neighborhood and were kind of scared, it seemed...of difference. (J1-13)*

John went on to describe the somewhat contradictory messages he got about diversity from his family during his growing up years.

*One, I can remember clearly in that white neighbourhood, as a kid, when this family moved in who had an African-- I would think now, looking back to it, he was African as opposed to, like, a black Canadian man. Very dark-skinned and three black daughters, all equally dark-skinned and a very blond, "stewardessy-looking" wife. I say that because it was the '60s and she had a certain kind of very mod, cool look. We were fascinated by that. And we were not to talk to them. Can you imagine? Because that was just too creepy and scary for my parents.... And I think that those kinds of things, in terms of how it shapes your thinking, just really, really continue to stand out in my mind ...all these years later...That early stuff...it changed my mind and I was always interested, always. Even to this day, when I look at my own dad, what is the fear? What is he so scared of? I don't know. (J-27)*

From John's view, his mother's response in the church parking lot to his derogatory racial comment was burned in his conscience, and made an impact on his awareness of difference and responses to it. However, of equal significance was his comment about how, despite their voiced beliefs, his parents seemed to be gripped by fear with respect to people of difference, including their African neighbor. This theme of fear of difference arose again later in his narrative when discussing his experiences as a manager on a multi-racial nursing unit.

Speaking about the early influences outside his family that impacted his approaches to justice and equity, John said:

*...I can remember clearly being fascinated by Trudeau.... you know Trudeau, I don't have to describe what he's like, whether you like him or*

*not it's a sense of understanding of the world that made us want to do better and be different.*

*And he made you feel that it was okay to think differently and think big. And, you know, he said that those things were heretical at the time, you know, keeping out of the bedrooms and whatever else, you know all the famous things he said....But there was a sense that he [was] in his position, to show you could be different and think different ...and we were fascinated by his differentness. And I was at the right age....when he was at...the height of thinking about the Charter of Rights and yelling that people had to celebrate diversity and pi\*\* off if you don't like it because that's how our country is going to be, and ...he said, You don't like it? I'll entrench it... I'll make it even more difficult for you. So that was all around us. So...that kind of early experience really was helpful to me. (J2-11)*

In addition to Trudeau's influence, other historical events impacted him significantly.

*I was also from the '60s.... I was just old enough to be understanding a little bit of what was going on in the States and at Kent State....And maybe I got some of those values and carry that with me. (J1-14)*

The early effect of such events instilled in him a dis-ease with the current societal ways of being. This dis-ease was helped into action by Trudeau's vision of a society with a clear commitment to rights and freedoms, and his "just watch me" attitude, which fanned the flames of John's fiery commitment to equity, fairness, and social justice. His admiration for Trudeau's irreverent, confrontational style was echoed in his admiration for the "lippy, strong" emergency nurses who caught his eye in his youth and diverted him from his plan to become a surgeon. It also became a trademark of his own style.

John talked about exposure to the American political scene of the sixties, and the dynamic leadership of Trudeau leaving him with a sense of privilege, similar to Mark's experience.

*...an innate sense that I'm probably very privileged, but not better than anybody else. And I had the luck of birth, to be born in a nice city and with parents who pushed me to go university and all those kinds of things. (J1-28)*

John's view of diversity was embedded in principles of social justice. John identified a vision of social justice as being central to nursing.

*So I think that overarching value of really believing in, wanting to make the world a better place is important. (J1-11)*

His view of difference was much broader than culture, ethnicity or race.

*When I think of diversity, I think of a lot of-- here help me, what's the right word? Differentness or different in any environment, whether it's...sexual orientation or gender or the color of your skin, whatever. Inclusivity, I suppose, in my mind, is about how we base that diversity or don't, and...how it plays out in our behaviors towards each other, towards patients and so on. (J1-12)*

John spoke of the value of diverse experiences and exposure to difference in creating different ways of knowing and being.

*And as I travelled to different countries and worked with different groups...I've just found that the diversity of thought that it brought to me, made me-- now I sound like I think I'm so smart. I was going to say, made me feel smarter or more well rounded, I guess is ...is a better way to put it and richer for the experience. (J1-29)*

The expectation in childhood that he do “something with his life that benefits people” drove John's actions around diversity. The memory of his mother's words in the church parking lot, talking about the privileges he enjoyed being an accident of his birth, created in him a commitment to service and action around issues of social justice—of “making the world a better place”. However, he observed a fear and anxiety about difference in his parents that contradicted their spoken messages. He grew up with confusing messages around difference that became more real to him when he experienced, first hand, what it meant to be in the minority. Like Mark, John spent time

in a remote northern Aboriginal community—time that would change his life and world view.

*And of course I had the unbelievable chance to go and live in a Cree community for that period of time.... I was in a Cree first nation in the north and once again, you walk in, you are the white person in charge, right. And the teachers are all white and...the real power is the guy who runs the store and he's white for sure and he controls the sugar and the glue and the booze and all that craziness....So there were very few people of Aboriginal background that I ever saw who were teachers or nurses or in professional kinds of roles. I remember the RCMP guy, who was Cree, spending a lot of time with me, talking about the torture for him of seeing his own people drinking or hurt or...behaving badly....You could see the pain in his face of being the, for him, the token person who had come back to the community in that position and then been seen as the enemy....But I think in terms of understanding Aboriginal people, probably I learned the most from patients themselves, because they were the ones with whom we had the most interaction. (J1-35)*

This experience of being in the minority was not John's sole experience of being Other. During his first year of nursing education, he was one of three men in his nursing class of 120. His educational experience as a member of a minority group left him with some scars. He talked about how he learned in later years what the faculty first year chairperson had said about the men in the first year group.

*[She] said..., "Do we really have to allow them to be in the program?" And she meant the boys. She hated us...and she so strongly discouraged us. I can remember doing my very first theory paper....I studied and studied so hard and read all on adaptation theory and all this kind of stuff and was so proud when I handed this in. And...she gave me a B+, I'll never forget it, and she wrote on the front, "This is either brilliant or you plagiarized it." And I was just*

*stunned...I mean, to this day, I have got a lot of flaws, believe me, but copying and cheating and lying, have never been one of them...I was shocked out of my mind. ...You're trapped, right, and you think this is the person who has all this power who smiled at me all the time....She just didn't like guys. I mean, she had a husband and sons and everything, but she didn't like guys in nursing....Real undercurrent of that unbelievable intolerance for men who often warrant it because they act like such a\*\*\*\*\* sometimes, right.... So I think because of those kinds of experiences, I had a real heightened sense of what it was like to be treated unfairly, based on how you looked. (J1-19)*

The implied accusation of plagiarism from a powerful nursing professor left him angry and devastated, and convinced that the accusation related to his maleness. Gender was an issue--both positive and negative-- throughout his career.

*But I think I got to where I am... based on something that does impact on diversity and it's gender. And I think when you're male, if you're not a doctor or an orderly, then you're an oddity in healthcare, for the most part. Maybe a few physios or pharmacy, right. But generally healthcare is a place of a lot of power for women, even though they might not feel it every day. And I stood out early because I was a guy and because I was doing nursing education. In other words, I wasn't on a track to become a doctor, which is still what a lot of patients ask you and nurses even ask you when you're a young male...It's not really a legitimate endpoint career for men....I was also not just doing nursing, but I was doing a baccalaureate....I was the first person in most units I worked in that had a degree. So that was odd and it was made fun of at the time....It was a shameful kind of thing that you had a degree and it was from that school where they don't know anything about bedside nursing and blah, blah, blah. So you're kind of having to prove yourself in a number of ways. (J1-5)*



However, similar experiences of negative treatment because of his gender did not follow him in to practice. Like Mark, John believed that, after graduation, his gender did not handicap him—in fact, like Mark, he expressed belief that it privileged him in many ways.

*But at the same time, I think I benefited from the positive token side of being almost always the only male who was an RN....I stood out...and then when you're smart, too, and you have half of a personality...it almost reverses where they push you to positions of leadership. So I was not in my job very long, my first RN job...before people started coming and saying, "Well, can you talk to this patient about this thing? You seem to be good talking with guys," or whatever. And it was a heavy unit with a lot of injured male patients...and the female nurses would say, "Well...we're not comfortable talking with him about sexuality. Maybe you could talk about that" .....And then it was, "Well, maybe you could run a little group and talk about that." And so I sort of found myself being...pushed along into those roles without ever really planning to do that. And the push went on from there. You should do your master's degree. Okay, eventually I did that. People around me, all women by the way, set those expectations for me....There was just this unbelievable support and it kind of lifted me along. (J1-5)*

Perhaps fueled by his own experiences of exclusion, or driven by the views of equality voiced by his parents, or possibly fueled by the social injustices he witnessed on a remote reserve, John went on in his career to actively work for the inclusion of people of difference in the profession. His earliest, and perhaps most powerful experience came when he attempted to increase the diversity of the staff on the highly acute unit where he was nurse manager.

*...To me the pinnacle of success...if I was to measure the physical diversity of the colour of people [on] the unit that I ran...which became known as this high diversity unit where...people would say it looked like the population of the city. There were lots of black folks, lots of Indian*

*folks, of course lots of Asian people....That diversity increased significantly during my five years there and because I encouraged it and others wanted it and it worked. So....some of it's actually very simple....some of it is you just have to do it, you know....I put some structures in place to help people that were likely to flounder. I had...on any one day I suppose, 120 to 140 people reporting to me across two very large units....And they were...35 or 40 percent black and another big chunk Asian, Filipino and Chinese largely and then white. (J2-33)*

*John spoke with affection of the ...women from every part of the world, who suddenly took you under their wing and made it less scary to try new foods and to talk about different religions and all those kinds of things that when you're young, start to introduce you to a bigger world than your own self. (J1-36)*

*However, introducing diversity within his workplace was not without its tensions. The downside... if there's one, is when you start talking about diversity sometimes you end up angering one group... 'cause you've overly favored one. I had a very upsetting experience as a manager, because I had...a couple of very powerful black women, who kind of protected me... (J1-23)*

*John went on to tell the story of this experience.*

*So I'm the young, pink coloured boy, who has a degree and is clearly being pushed to become the manager of these women who trained me 15 years earlier. And now I'm suddenly in the uncomfortable position, once again, of being the educated white boss to a lot of black and Asian women, right....And....a couple of the more senior West Indian gals, who had liked me from the time I was a student and mentored me and pulled me along, decided that they were going to protect me as the head nurse, because they knew that people were going to eat me alive, right. And there [were] people there who, you know, in any bell curve, half of them hate you in any one day and half really don't care one way or the other about you, but*

*they wouldn't kill you. So XXX and a couple of others decided that their mission through the five years was going to be that they were going to keep this crowd at bay. And somehow the relationship I had with them, which was protective of me and...for which I will always be grateful, got to be interpreted that I was favouring them. And then in fact I ended up having quite an altercation with a couple of other fairly senior nurses, who said I didn't like Asian people and ...it was totally craziness....Well, no matter how you struggle to try to provide a situation of equity, I guess, and inclusivity, sometimes you can't help but be seen by some as not liking a certain group....It was very painful at the time to feel that accusation, you know. (J1-25)*

John's early experiences with difference introduced him to the fear that is engendered when homogenous communities encounter difference. His story of his parents' reaction to the arrival of a black family in the neighborhood revealed a basic contradiction between their espoused values of inclusion and their actions. The experience of tension played itself out on this unit as he tried to increase diversity on the unit. Fear also played a role in his experience with a young black man whom he hired to work on the unit.

*I needed male help on the ward because the care is so heavy.... I was trying to hire some attendants who...who could lift and stuff....And one of the other head nurses said....she had a guy who was very strong, but he's a lot of trouble. And that...he just doesn't get along with anybody. But he might be okay with you....To me, it was like somebody pawning off their worst employee, right, I think I'm getting the worst of the worst here. But he's already been oriented at the hospital...I go meet this guy. He's six foot seven, black, very dark skinned, kind of tough looking, 21 years old...You could tell when you talked to him, he needed a little bit of life training. I'm telling you, he was the best employee I ever had. But people decided...that he was big and scary and black and he was fine to wrestle people when they wanted that... [but] he didn't have the skills to be gentle*

*and nice. And he needed someone to say, “XXX, you can’t wear...your pants sagging down around the back of your a\*\* and you can’t carry your personal cell phone on your belt...while you’re doing care and answer it to talk to all the girlfriends.” You know, within three months or less of me just looking at him up the hall and pointing to his pants and saying... “Pull them up and ditch the phone,” ... he was fabulous. Patients loved him and he was gentle and-- of course he was huge, so he could lift and stuff.... I had a number of those kinds of interactions, I guess, through my career...where I think people saw, wow, that’s different and tolerated the difference in some cases. (J1-16)*

In this instance, fear was mitigated when John established a relationship with this young man, took an interest in his success, and helped him learn the ways of the unit. With this mentoring and support, the orderly’s behavior became less “scary” to those around him. By role modeling acceptance and commitment, John was able to send a message to the rest of the staff saying “This young man is here to stay. He can play a valuable role here. Let us make him feel welcome and become part of our unit family” Leadership, role modeling, education, and establishing clear and expected standards of interaction and practice for both staff and the young man involved, all played a role in the success of this young man’s integration into unit life. This story mirrored Mark’s story of success in working with the “rough around the edges” nursing student with the musical gift. In both instances, the commitment of these leaders to these individuals changed their lives, and impacted the culture of the environment around them.

John’s experiences revealed the propensity for conflict and tension that exists when promoting and increasing difference within the workplace. In addition to the story previously told of tensions between two ethnic groups on the unit because of his perceived favoritism of one group, John recounted stories of racism experienced by the visible minority staff from patients.

*And I never really knew how to handle that, except I think what was helpful is I always talked about it openly with the staff. And I can remember across from... my office door, there was a private room and*

*there was a woman in there who would have been sort of 60's, 70's...you know, ringing a bell and yelling insults at a black nurse who was the sweetest, most lovely young woman you could ever meet. And I went out into the hall as she came out of the room, crying at one point and said, "Oh, Kathleen, I'm so sorry, what can we do?" And she said, "Nothing, I'm going back."...She went back in, but what helped our unit function among a lot of difficult patients...was creating sort of a safety zone....But I didn't have an answer for all these things and never pretended to. But then I at least tried to empathize with the pain of what it felt like to be called the "n" word and then to have walk back in and provide care to somebody like that. (J1-26)*

Like Mark, John spoke of the importance of leadership in creating "safety zones" for the diverse people he brought into nursing. Whether the reference to a safety zone meant a physical space such as his office, where a minority nurse who had just been denigrated by a patient could calm herself and regroup in order to go back in to the patient's room, or a cultural space of support and acceptance, he identified safety as a key issue for minority nurses.

*He related this discussion of safety zones to his own history in nursing. I've given you several examples from famous people to my individual teachers, but they were people who, almost in every time, struck me as making me feel safe. Making it okay to think differently, whether it was a different way to apply a 4x4 dressing or a different way to create a whole healthcare system. So there's something that... makes the differentness...okay. Maybe that's part of what fuels my interest around diversity and my ability to talk about it or something....But that safety zone maybe is what I sense from those people.(J2-18)*

Like Mark, John identified the importance of leadership in creating safe spaces for the exploration of difference and where difference was acknowledged, supported and deemed "Okay".

However, John was not convinced that nursing as a profession understood the need for such safe places, or that it had any commitment to creating such places. John confessed cynicism at the prospect that nursing as a profession was ready to embrace diversity, not only on the level of physical difference, but at the level of what he referred to as *diversity of thought*.

*...I think there is next to no actual commitment to inclusivity and diversity of thought in nursing and by thought I mean different thinking.*

*...There is no room...in nursing, for any diversity of thought and when you try to really create change or ask questions, there is an unbelievable inertia in nursing, whether it comes to diversity or almost any kind of change. So I think that has held us back and is part of the reason that there is no diversity in the color of nurses... above the entry level. (J1-15)*

John, like Mark, embraced a view of diversity that is not limited to culture, ethnicity or race. His commitment to inclusion was not in any way dependent on skin color, nationality, or language, but was a part of a grander vision of social justice. He saw diversity as inclusive of all of those who were marginalized by the profession. He saw marginalization occurring, not just on ethnic, cultural, or language lines, but based on how the profession perceived the ability of the marginalized group to *conform*. He used the term rejection of *diversity of thought* to describe the profession's lack of willingness to explore possibilities, and its demand for sameness.

John was especially skeptical about true meaningful change in the way the profession approached patients and health care, beyond simply recruiting people of color in to the profession.

*To do recruitment and retention of Aboriginal people in health professions, I always come to that table with a heavy heart. Thinking it's fine to recruit [an Aboriginal student] into nursing and put all kinds of programs in place to get her more science and mentor her....Maybe we can get her through, but what do you do on the day she graduates and walks into [one of] those places, that still treats everybody the same as it did 25 years ago-- I mean, I shouldn't say that. They have days where*

*they have Jamaica day and you wear your national dress and...we have Jamaican food in the cafeteria that day... I know there is an effort to be made to be jolly about our differences in how we dance and so on. And I think that's fun and fine, but when you actually say, well, now we're going to change how we actually do something with patients or how the hospital is run, the sh\*\* hits the fan. (J1-40)*

Addressing the lack of diversity in nursing education, and the impact on diversity within the profession, John said:

*...In general, our teachers look like the majority and think like the majority and we probably attract those who look like us. There's plenty of research that shows that where there's...been a male dean, for example, there suddenly turns out to be a lot of male students. We see some of that,... with the cultural piece. But there still is, I think, a bit of a closing in of the ranks.... But...Connie Curran, who used to be the editor...of Nursing Economics, said 20 years ago, nursing...is the purview and sort of guarded place of power, of "nice white women from the suburbs." And if you are anybody else, God help you, if you want to get in and stay in. So there's an awful lot of talk about diversity and every hospital has a...little statement on the wall beside their accreditation and...there's all kinds of verbal attention paid to it. But when it comes down to really diversity of thought, which is some of what we're talking about, acceptance of difference, I just think the sh\*\* hits the fan. And what we really want is nurses to behave mostly, the system wants them to behave and conform and they largely do....But all of that, to me, plays out in the diversity area as well, which is basically conformity, sameness. (J1-38)*

Citing a prominent Canadian nurse's viewpoint on the ability of nursing to embrace changes such as increasing diversity, John quoted him as saying:

*... "A lot of us...we just have to have the grace to retire or die and get out of the way because we can't bridge the gap."*

John agreed.

*We just have to leave and let them sort of start anew....So hence the paradox.... as long as we're here, maybe we can't fix it and yet...we're trying to fix it, but...we ourselves are the barrier, our generation and older. So...that's the sad part...that balances my enthusiasm and hope . (J1-43)*

*I just have a terrible kind of worry at the institutional level, at the society level, that we haven't made the leap at all to really be inclusive. We have all the diversity, because it's all there, but you kind of better stay in your place.... (J1-40)*

When asked what his message to nursing leaders would be with respect to increasing diversity within the profession, his message was clear

*I'd say: Ladies and token gentlemen, we need to get our sh\*\* together and think big and bold and scary and shake off...some of the cobwebs and move it...along. Around the issue of diversity, specifically, I would say what I say in every room: First of all, look around, and then I would say look at Canada and imagine ...a nurse who has tattoos and a couple of little piercings and they're going to look different and act different and talk different....And I often say, deliberately, to groups of deans and VPs, 'that's who we want to recruit'. How are we ever going to bridge that gap? (J2-45)*

The issues posed by lack of diversity at the formal leadership, policy making and influence levels of the profession were of particular concern to John.

*But then you sit in the head nurse meeting and look at the 30 or 40... managers around the hospital and there was one single person of colour. And in almost any room I go into... any kind of group of nurse leaders and I stand on the stage and look out at 300 or 400 people.... You can look around the room and you can see right away the diversity, 'cause there's only three. Oh, there's the Indian lady, there's the Chinese guy and where's the black person? Oh, there she is. No Aboriginals at all,*



*needless to say. So I don't know what better story to give you. The trap, the glass ceiling is there. Whether it's by choice, I don't choose to rise to become the head nurse, that's part of it for some people. And yet... many, many white folks clearly have dreams of leadership and they get there. So I can't believe that all those other people, First Nations or black women or whatever, just decide as a child, well, I'm going to just do hands-on for all eternity. So I think that is in our faces. (J1-16)*

John indicated that what is needed to create the necessary changes in the profession with respect to diversity is leadership. Unfortunately he was not completely confident of the commitment of nursing leadership at this time.

*So those ladies and gentlemen probably don't look at a young Aboriginal boy or Hispanic girl or whatever and say, gee, I really want you to replace me. How do I get you into this system? ...I just don't think it's on the radar...at all, even though there's lots of talk about pipeline programs and diversity. When it comes right down to what we'll do in the profession to actively engage these people and get them in and support them...so that they become head nurses and directors and decision-makers....I just don't see that's it's going to be successful. (J2-46)*

*And I have friends in other industries who continually tell me there's nothing special about [nursing] ...that it's hard to find that diversity [in any profession]. But I'll tell you when I walked onto an Air Canada flight recently from Newfoundland and the pilot was a young blonde female and the co-pilot was a young black female, I nearly fell out of my chair... So I thought what an interesting, obvious change, you know, in an industry that you think of as absolutely the purview of men, and mostly white men, and I smiled the whole way home. (J2-47)*

In summary, John's view of diversity in relation to nursing was a broad one, encompassing not only physical difference, such as ethnicity, gender, or sexual orientation, but also diversity of thought. John was not confident that the profession was truly ready to embrace diversity, and his frustration with this lack of vision was palpable.

He cited the need for leadership to move the profession forward. Our conversations moved to a discussion of leadership in the profession.

### ***Leadership***

John's view of the role of leadership in challenging existing practice in nursing revealed a strong commitment to and understanding of leadership, rooted in along history of formal and informal leadership roles in his life, and in the profession.

**Early influences sparking leadership.** As with his interest in diversity, leadership has been on John's agenda for many years. John jokingly referred to a long held interest in leadership.

*And when I was young I can remember thinking that I wanted to be the prime minister....Not an-- ungrand little dink was I at age 12.... nothing like I'm going to be a teacher...I will be the prime minister....That didn't come out of my parents. I mean they were great, they said you can be anything you want, you're going to go university....And I can remember-- I used Martin Luther King and even Malcolm X because I'm of a certain age because those were the people that were on TV, right?...But I can remember thinking: Oh, I'd like to be able to talk like that. So just something about seeing inspiring people, I think my mutant little brain was open to that. (J2-23)*

### ***Critical Leadership***

Critical leadership involves reflection on the power inequities in society. John clearly accepted the need for addressing the injustices in society.

**Critiquing injustice.** John attributed his visibility and reputation for success in the area of leadership for diversity in nursing to his impatience and frustration with existing conditions and injustices.

*...My sense of angst I suppose hasn't really gone away...and I think that's important. I remember when I went to one of my national level jobs, XXX [a well known Canadian nursing leader] said, "You come with all the...angst...of the clinical setting and the frontline", because I had literally just come out of that, and she said "And I don't want you to lose*

*that because we need people who can remember,” because so many leaders who are in decision-making structures are so far from remembering... And I have noticed that we mellow, I think to, some degree with age, maybe all of us, but I’ve tried to not lose it. (J2-31)*

Like Mark, John experienced considerable angst and dissatisfaction with the status quo in nursing. While passionate about the profession, cracks were appearing in that passion.

*The part of what I hope to continue to bring is how do you spark excitement and get the ball rolling and get things done...and I think that I still have a bit of that edge, although I’ll be honest I’m getting tired. Getting tired. (J2-32)*

Challenging the profession to do better in embracing diversity, John’s angst and impatience were palpable. There was also a certain sense of the ominous in John’s simple statement that, with respect to the fight to increase diversity, he was “getting tired”.

**Leadership and conflict.** John’s stories revealed themes of conflict that occur when diversity is increased within the profession. These stories indicated the presence of conflict between patients and nurses, but also between groups of nurses. This conflict results in the need for addressing these tensions. John expressed a desire for nurses to be more willing to take on difficult issues. He called for nurses to

*...not ...[be] afraid to have some hard conversations. ‘Cause we don’t do that sometimes in nursing. We shy away from it a bit. (J1-9)*

**Understanding and using power as a leader.** John talked about how he came to his understanding of power and its importance to leadership.

*I don’t know if you know a woman named Kelly Munroe. Well, Kelly was the VP of everything that mattered at XXX Hospital....And I can remember, she would often sit on her desk, like sit right on it, facing the room if you were in front of her and crossed her legs and look really, really intimidating. And she could make people leave her office who are really tough, tough people and she could make them leave crying. So she*

*had a lot of ability to do that, some of which I think is bullying and horrible, by the way.*

*But early on, she and I got into it about something. It was related to what I perceived...was the bad behavior of someone working in gerontology and I was tired of their craziness. And somehow I exploded and...why I ever thought I should go to the VP and have a rant, it probably shows how immature I was at the time. Anyway, I was complaining about them and Kelly Munroe sat on her desk and crossed the famous legs and stared me down and said, "Have you got a problem with conflict?" And of course I nearly peed my pants 'cause I knew I was now going to be the one who left looking for a cigarette and crying. And how that eventually played out, that conversation, is that she said, "Those people have nothing and they're doing this because they're trying to create a base of importance and power"....She said, "You have all kinds of power." And I said, "What are you talking about?" I was the clinical instructor I think at the time. She said, "You have all kinds of power so you can't understand this." And I said, "I don't have any power, what are you talking about?" And she said, "John--" and she was angry at this point, you know, looking at me like I was one step from being a gerbil with a broken leg, right, and said, "You...have power, if people think you have power and you need to carry that with you always." And she said, "People think you have a lot of power around here, so you better get it into your brainless little skull," is probably what she said, I don't remember, "and use it properly." And she also, in that conversation, reminded me that there was the flip side which is, there's all kinds of people who have no power because people think they have no power and treat them that way. And of course here's me whining and being an idiot. But it really played out, her piece of wisdom really-- I've thought about it so many times through my life, you know. (J1-32)*

The importance of an understanding of power in creating change and providing leadership was crucial for John. His confrontation with Kelly Monroe identified for him the importance of understanding the context of power, and that power needed only to be perceived, rather than real, to be effective. He identified power as a social construction, based on perceptions, in this case, of the relative power of acute care services in the health care system in relation to gerontology services. He also acknowledged the importance of people's own perceptions of their power, and how those perceptions are shaped.

*But I see that now with youth, how we treat young people, like they're kind of stupid. And you know for sure, we dismiss First Nations and Inuit and Métis people a lot for the same reasons. We do the same with...new immigrant women who don't speak perfect English. Like they're kind of stupid or they're not very intelligent. Doesn't matter they were a surgeon in Sri Lanka or whatever. So I think that some of Kelly's things she said to me about power and how you use it, really stuck with me for a very long time. (J1-34)*

Understanding how power was perceived was important to John in developing his strategies for moving the issue of increasing diversity forward within the nursing profession.

### ***Transformative Leadership***

The desire to transform society, health care, and the nursing profession was driven by John's passionate commitment to social justice, but also by his angst at our failures as a society and a profession to make things happen at a pace that satisfied his expectations.

**Passion for transformation.** Speaking about the passion that he felt for the issues within nursing as a profession, John described an overwhelming drive, a compulsion to keep going.

*You know, XXX [a prominent Canadian nursing leader] once [said] ...when I was wanting to jump out a window...that it was like a decade-long boxing match where you have to keep getting smashed in the*

*face and wipe the blood off and get back up and say, "I want more." (J2-10)*

John's love of the profession, and his preferred vision for its future were obvious. Of the way in which nurses interacted, and worked together, he said, "And I fell in love with the idea of it and still feel that way 30 years later." But like Mark, John exhibited signs of moral distress at the inertia of the profession in addressing and embracing diversity. He was driven by the uplifting experiences of success, but also by a sense of failure. His commitment is fueled by his sense of justice, but also by those around him urging him on.

*So I think in terms of what... sustains [my] interest in it is that I continue to feel lifted by those experiences and every single day, literally every single day, see at least some incident where I'm saddened by the way I see people treated... So much lost promise....So the sense of the mission being incomplete, I think, probably always lies within people who are interested in social justice. So I think that's what sustains my interest, my inherent belief that...we need those people to succeed, for ourselves to succeed. And I also have people around kicking my a\*\*. (J1-30)*

**The importance of vision in leadership: A "grander, bigger purpose."** While passionate about nursing and diversity, passion was clearly not enough to sustain John's commitment in the face of such challenges. What also sustained him was a sense of vision about how things could be. He talked of the success of leaders who can share their vision.

*And, you know, I see that in people from bedside nurses and doctors to President Obama. So there's something in those people that have a grander sense of purpose maybe about the world that to me always elevates them away from the task at hand although they understand the task at hand. So to me it relates to that bigger vision, bigger sense of purpose, a sense of courage and ability to look at complex and broad situations and break it down even when they're really scary situations so that people can kind of bite off chunks and keep going... You know, there's*

*just some sense of who... people [are] willing to follow and what is that something about those people. I don't think we've ever really defined it very well. Something...around leadership to me relates to perseverance and the ability to keep going. (J2-9)*

*And I saw it...in a head nurse in an emergency department I worked in who just had a constant sense that it could be better and it could be different and you didn't need to be afraid, you know, to step up and make change. And she took everyone who had innovative thoughts and pushed them to the front and dealt quickly with people who couldn't get with the program.*

*And those kinds of people to this day fill me with hope... and...that sense of being inspired by that grander, bigger purpose. And it can be...how are we going to run this nursing unit better, it doesn't have to be Obama every time, but those people are everywhere. And to me...that's what I think about when I think about leadership is that ...bigger thinking even in-- I was going to say in smaller people but in people who have sometimes very simple roles in their work but they're still able to do that. (J2-11)*

John talked of one of the challenges for leaders in nursing-- the high stakes that exist in the day-to-day that make it difficult to look beyond. He believed that these stakes were so overwhelming

*...that you become so embroiled in the moment. And I think we have terrified nurses with the threat that no matter what happens someone will die and you'll lose your license....There's always the license hanging over your head. We tie them to bells, literally, kind of like dogs, you know, like Pavlov's dogs, that's the bell and somebody runs, and it's normally a nurse or a doctor, and ...our thinking is necessarily tied up in the moment....You know when I talk to nurses...who sometimes have said...well why are our national organizations spending money and time on this issue or that issue? And when I say what might nursing be like if*

*we had had a few people through the years who were paid to sort of sit back and talk and have the grander dialogue, might we be in a different place, because you all tell me...you're not happy in your role. So we have this sort of cycle of unhappiness that goes on and on and on... and I think it's tied up in the busyness of the moment. ...You...can't not respond when there's an arrest or some nice lady falls and on the floor and...it just repeats on and on and on.... And the big thinking is seen as being superfluous...or frivolous...And I do think it's because we're wrapped up in healthcare and some other industries too, in the busyness of the moment. (J2-15)*

John identified the challenges of the profession with respect to the grander, bigger vision. Held captive by the “busyness of the moment” and the ominous and ever present prospect of catastrophic patient outcomes, resultant litigation and loss of licenses, nurses were seldom afforded the opportunity to look over the cliff to the horizon beyond. The need to maintain control in the ever-changing minefield of patient care posed a particular problem for nurse leaders.

*Being a leader...I would always challenge people to step out of it, step forward and out and away, and imagine...what do I want the tree to look like that I'm planting now, 20 years down the line. And try to get out of the murky mire of the minute to think about...the bigger piece and what is our part in making that bigger piece happen going forward. (J2-48)*

As a way of describing the difficulty nurse leaders have in imagining a different way of being, he recounted a story about a major health care institution in central Canada that invited him to help their nursing leadership re-envision the possibilities for their organization.

*...And they still have nursing stations there like they do in most hospitals where... there's 14 nurses on duty. There are nine chairs in the nursing station and three computers and yet we want everyone to do everything on a computer, right. So we right away make it impossible for people to work. So nurses write everything on pieces of paper like it's 1943 and*



*then they spend an hour transcribing it. ...So I said, why don't you buy them all, on hiring...an Acer laptop that they have to use at work and a Blackberry to communicate? They went mental they were so mad at me. "Well, we don't have \$5,000!" I said, "Okay, first of all, step back, an Acer laptop is \$399 and you'll get a great package deal with 1,000 nurses on Blackberry used time, right. And if you look at XXX General-- They...dropped their sick time from... through the roof to zero, in...three months in the ICU, by giving every doc and nurse a better communication tool. ...Because they were making each other mental being unable to reach each other and to communicate and... they're so happy with that simple thing. These guys went insane. I said, "Are you telling me, with ...an \$80,000 a year registered nurse, you wouldn't make an investment of \$500 in her orientation? And knowing that it's going to keep them longer and make them happier?" ...I've gone across the country a lot...that's the reaction I get all across the country from leaders....Some of them just can't imagine a difference, different way of doing things, and they cannot possibly imagine how different that generation is that they're trying to recruit. So...when you overlay that with the problem of diversity, that's where some of my frustration and sadness comes from. That it's layered at so many levels in nursing that values conformity, that when you throw into it a gay, black male, people just can't handle it....I hate to be sounding negative or cynical...I feel sad and that's the conversation, if I could have with every leader across the country, it would be-- I would love us all, including myself, to be able to say, I am part of the problem and...what could I possibly do to get out of the way... (J1-47)*

John's frustration with the profession rested in its lack of willingness to recognize and create opportunities. While his example of the large institution where the staff resisted the discussion about technology did not deal directly with the issue of diversity, he used it as an example of the lost opportunities which limited the profession in many

ways. The overarching tone of John's story was one of disillusionment and frustration with the profession and its lack of willingness to explore such possibilities.

And so for John, passion, angst, and the ability to see the way things could be drove him to transform the nursing profession. But he warned that it is all getting pretty overwhelming for him. He is getting tired.

### ***Educative Leadership***

Leadership from John's perspective meant engaging others in ways of change through strategy, opportunity, and mentoring.

**Leadership as strategy.** Leadership for John was a strategic process. John described his consultant role as that of a "thoughtful provocateur", one which gave him the opportunity to look at things from different perspectives. He described his role as being

*...honest with a kind hand I guess. But-- and also a sense of fairness and an ability-- I try to have an ability to see things from a lot of angles and I'm not one to try to find a middle ground as much as I'm often one to try to find a different route or a third-- you know, a third option if there's two sides to a situation. (J2-21)*

**Creating and recognizing opportunities as a leader.** In John's view, creating opportunities was not based in compromise. He advocated looking for different opportunities rather than simply neutralizing dissent by choosing the middle ground. He advocated for new, creative, big, bold solutions, not conciliation and concession.

John identified the importance of taking risks and exploring potentials in growing as a leader. He talked of how relatively early in his career, he left his world of frontline manager to enter the world of influencing policy on a national and international scale. This journey started when he was working as a research assistant at a central Canadian university.

*And walking down the hall one day, I walked into XXX [a prominent Canadian nursing leader with whom he had worked previously] .... And she said, "Oh, what are you doing here?" ...So I told her... "Nothing, I'm not employed right now...I took some time off." "Do you want to come*

*and work for me...” and I said, “Yeah, of course.” And I was there two weeks later and again...that offer arrived out of a good relationship with her, opportunity. I said yes to a lot of things through my career and probably said yes to too many and made myself tired at times... But I said yes to a lot of things and got a lot of experience and the yes to XXX was the thing that changed my life...in terms of pulling me away from the fatigue of frontline care... and put me into the policy position. (J1-8)*

So keeping an open mind to opportunities that presented themselves led to a life-changing shift in focus for John—and it was entirely unplanned.

*But...this place was not a planned career trajectory at all. It was serendipity, timing, preparation, because I didn't do too many things that I was unprepared for..... All those kinds of things that set my ability to then go on and do those things on my own, many, many times through the years in the future. (J1-8)*

Like Mark, John recognized the importance of saying ‘yes’. As a nurse manager, John strove to create a nursing unit that was seen as diverse and reflective of the community it served. In doing so, he demonstrated his straightforward approach to addressing the issues. As he indicated, “...Some of it’s actually very simple... some of it is you just have to do it, you know”.

He spoke of this need to say “yes”, to consider the outrageous, to entertain the possibilities and above all, to have courage and confidence in one’s abilities and one’s decision making.

*But saying yes to a lot of things made a difference to me....It adds little pieces to your story that interests people and it was really, as I say, completely unplanned. And...that piece becomes part of your history, just because you said yes. (J1-9)*

*I think as you get older in some ways you get less afraid. (J2-20)*

Saying yes, from John’s perspective was a key aspect of leadership.

**Leadership as mentorship.** Leadership for John also involved mentorship. John talked again about his experience with the large central Canadian hospital referenced

earlier, and the attempts of their leadership team to re-envision what could be. He talked about a successful experience in establishing a unique mentoring program there.

*So I had all their leaders in nursing together for a full day and I made a comment about the technology early in the day... These were head nurses and up, okay. ... The most senior directors would have been 55 to 65, let's say.... I make this comment early about my friends who are young, who won't answer me unless I do it in a very specific technological way. And one of the leaders gets up and says, almost...proudly, that she's never sent a text message in her life and doesn't even know what that is. And I ...looked around the room and you could see the faces of the young head nurses... dropping, right. So I sort of made a joke, said, "Well, I'm going to teach you, so let's do it-- let's send each other a text message now, 'cause it's really easy"...I thought she's totally embarrassed herself, right. But that's kind of what we're facing and what I did with that group and what they're implementing in a pilot ...is ...a mentorship program. But the mentor is the new employee and the person who's mentored, is someone who is over the age of 55 and is...a decision maker. So it's not just... based on age because there's lot of people who are—like...I can send a text message and I'm not, like, 20. So some of it's your attitude. But in general, right, there's some understanding that the older we are, the [less] we're familiar with different technology. Anyway, so the new employee is always paired with a decision maker in the organization and must teach them about laptops and Blackberries and whatever it is. ...The older person shows them the organization and how the business runs.... They really latched onto that notion; I have to give them credit. (J1-46)*

Mentorship for John not only involved being a mentor, but also involved the building of organizational mechanisms, both formal and informal, whereby mentorship could occur.

### ***Ethical Leadership***

Leadership for John was about honesty and sacrifice.

**Honest without being mean.** For John, leadership demanded honesty. He talked of the need for nurse leaders to have the difficult conversations that go along with increasing diversity, identifying a tendency in nursing leadership to avoid such conversations. Having honest and authentic conversations was challenging, and required respectful sensitive approaches.

*I've tried to live this way... [with] a sense of ...being honest without being mean, because sometimes – well...honesty isn't always nice. (J2-21)*

**Commitment and sacrifice.** Leadership, according to John, also entailed sacrifice. He talked freely about the enormous toll that being a leader can take in attempting to achieve one's vision.

*And in a busy healthcare system where everybody's pretty stressed out...I do think it continues to be a very difficult to say to people "Can you now take on one more change?" .... When they just say, oh, if I just conform and if we just get this done and get through the day and nobody dies it's a good day. And so I think some of that resistance is fatigue. Vince Lombardi used to say, "Fatigue makes cowards of us all." And I've just felt that so much through my life, you know. "...Please make it go away and let me get my thing done." (J2-17)*

In summary, leadership for John was clearly about passion—passion for justice, passion for the profession. It was about a vision of transformation of society, of the health system and of the profession. It was about being able to entice others to share your vision. It was about being strategic and understanding power. It was about conflict, and having the difficult conversations with honesty and compassion. It was about being a mentor, and ensuring that mentorship occurs for all. It was about creating and recognizing opportunities for one's self and for others. It was about transcending the demands of the everyday, to look toward the horizon and search for possibilities there. But the cautionary note in John's story of leadership was that it did not come without a price. "Fatigue" as he said, "makes cowards of us all".

### *Professional Closure*

John acknowledged that there have been barriers placed by the profession that impacted the ability of minority groups to achieve success. He talked of his attempts to move minority staff members on an acute care unit into positions of influence.

*But it was tough and, of course, quite frankly...a lot of those folks didn't have the same education....Many, many more of my nurses with degrees were white. (J2-35)*

He talked of how nursing as a profession inadvertently limited participation within it as educational requirements increased.

*There's a couple of interesting studies that show that every time you add one year of time to an academic program, you reduce the number of candidates from non-traditional backgrounds, who can afford to apply and who will remain in it for the extra year. And there was a really interesting study done in the States that looked at why academic medicine had lost so many black physicians through the last century. And they really tied it very interestingly to the constant growth in a number of years of training required to become a physician and they really have completely stagnated their growth of blacks and Hispanics in a country that is bursting with blacks and Hispanics.*

*...I have a colleague ... [who] was many years the dean at a major university in the southern USA....Only black dean of a big university in a state where 70 percent...are black...and she said, "I regularly graduate 175 RNs where every single one of them is white....And yet she said the LPN program regularly graduates 175 black LPNs. And she said people still believe it's entirely coincidence that all the black LPNs-- or all the black girls--...her... words-- say "let me choose a more limited career track, I can't really advance very much and I'll never get to be a leader. Let me pick that." And the white girls all [say] ...no, I'm going to take the other one... (J2-47)*

John clearly saw practices in nursing that acted as professional closure. He was unwilling to believe that nurses from minority groups simply viewed their roles as frontline ones, and did not aspire to leadership positions. He identified the disproportionate number of minority individuals in licensed practical nursing programs as opposed to baccalaureate programs, and in front line nursing jobs as opposed to leadership positions, as examples of nursing's "glass ceiling", and he challenged the profession to facilitate mechanisms that minimize these barriers and therefore optimize full participation for minorities in the profession.

### ***John's Story: Conclusion***

John's views on leadership for diversity in the nursing profession were perhaps best summed up by the following statement.

*I don't mean to be giving you a lecture, I just mean to share that it makes my heart sad that, in some ways, we've come so far and then I look around other days and think, oh, my God, oh, my God....We haven't come a single step... (J1-41)*

The overall message from John's story was one of angst and frustration. Committed to social justice and inclusion in the profession, John saw nursing as excluding not only those traditionally viewed as marginalized, but anyone who possessed diverse approaches and thoughts. The picture painted of the profession was one of closed thinking and obstructive action. While his passion for the possibilities of his profession remained intact, his ability to act was waning in the face of the fatigue of many long battles.

Passion, dedication, vision and frustration—these are the themes of John's narrative of leadership for diversity in the nursing profession.

### **Katherine's Story: Out of the Cocoon or "Banking Good Will"**

Katherine grew up in a mining community in northern Canada. Following high school she attended a baccalaureate nursing program at a central Canadian university. On returning to her home town after graduation, she worked in a variety of institution-based and public health positions. It was later when she moved to western Canada that she began her love affair with nursing education, a career about which she has been

passionate for over 30 years. Beginning her teaching career in a hospital-based diploma nursing program, she eventually moved into teaching and administration positions at a community college, where she was the head of the nursing division at the time of the interviews. During her tenure as chair, the college initially offered a diploma program, and then moved to a collaborative baccalaureate partnership with a local university. Under her leadership, the college was recently granted the right to confer its own baccalaureate degree in nursing, a development that Katherine viewed as the pinnacle of her success as a nursing leader.

### ***Diversity and Inclusion***

Katherine spoke of how she came to be a nurse. Like Mark, a guidance counselor played an important part in her choice.

*I was...in high school...in the... university stream in grade 13 and we had career day....And I really didn't know what I wanted to be. But so many of the girls in my class [wanted to be nurses and] were going to the hospital and they were going to get to see all these neat things. I thought, oh, what the he\*\*, I'll go there. So I went on that career day and I thought, you know, I think I could really like this. So I decided then that I thought that I would pursue nursing....So I told my parents and I'll never forget this...One of the school counselors asked to speak to my parents about my career choice...He said to my parents, "I'm going to ask you to consider something. You might think this is odd, but if she wants to be a nurse, I think you should send her to a university nursing program." And my parents, I don't think, had ever heard that nursing was even in a university. So that's how I ended up going to university to take nursing. And I never looked back from there 'cause XXX was... a pretty well known and well respected university.*

*But I always remember thinking...imagine a high-school counselor having that much savvy in 1965 to say if you're going to let her take nursing, please encourage her to go to university to do it. (K1-10)*



Despite the serendipity of her arrival at nursing as a career choice, she blossomed in the profession. I asked Katherine what prompted her interest in leadership and diversity.

*I think I've just always been like that. I know that I was raised in a family where the expectations were high....My dad was...working the mines. And ...my mother was a homemaker but she had had a decent education herself....My dad worked his way up...he was sort of the last of the group that went from labor to the... top of the heap. He was the general manager of the mill when he left work. And he started as a floor laborer....They both valued education and they were relatively forward thinking...I always knew, you know, the standards were high....So when you got into school and into university the expectation was that you would perform well....But to say that I remember one particular person or situation influencing why I have this egalitarian approach, I can't say that I do. (K1-31)*

Katherine talked of her exposure to difference in her youth. While her community was predominantly white, she was exposed to European immigrant cultures.

*In terms of when I was growing up... [in] the ten houses on our block there [were] probably ten different cultures represented and...we all grew up together. And mind you, all the little prejudices those cultures have about one another [were] part of it, too. But I ...was exposed to a lot of different cultures, not Aboriginal, but French-Canadian and Eastern European. So, you know, we had lots of kids that all mixed together....But my understanding was pretty limited....I knew that Ukrainian people liked...perogies and-- Italian people liked spaghetti and the Catholic kids...had to eat fish on Friday and that was about it, right. But, you know, in terms of any depth about those cultures, no. (K1-35)*

Unlike the stories of previous participants, Katherine's story did not include a personal experience of being different. She described a childhood spent in a largely white

European community, where there were some cultural differences, but a general presentation of homogeneity, from her perspective.

Perhaps as a result of her own lack of personal experience with difference, Katherine's approach to diversity and inclusion was a more pragmatic, less visceral approach than was portrayed in the stories of the previous participants.

Describing her exposure to diversity in university, Katherine indicated that there was little diversity in her class, and even less inclusion of diversity in academic courses.

*And my nursing education... I don't recall in my class anyone...whose background was not sort of white middle class. There certainly was no one in the class at that time that would be of-- anything that we would call a culture different than our own. So that was my experience.*

*In terms of our education...the only thing...in my program that I remember that specifically addressed culture in any capacity was an elective that I chose to take called cultural anthropology. And what I remember about that was that it was very academic and the person that was teaching it had done some research in Borneo or somewhere. So it was, you know, really based on anthropological principles in a culture that was really not one that—[one] was likely to run into in the streets of Canada. (K1-2)*

Her exposure to diverse populations began in Katherine's early days as a public health nurse. However, these experiences were limited.

*After I graduated I moved back to my hometown and I worked in nursing there.....And...there were a number of native patients that we would run into and I don't recall at that time anything in terms of staff development or anything of that nature that would have given us anything additionally knowledge-wise in terms of dealing with Aboriginal patients in the hospital. I then went to public health and in public health I did have some people that were different cultures but they were still primarily European. I had no involvement really with Asian cultures. I had no Aboriginal families in my area. (K1-2)*

*Then in the mid-70s I moved to [western Canada] ...and that's when I started teaching.... I taught at the XXX Hospital School of Nursing. And, again, the vast majority of the student body would have been what we knew as traditional nursing students. And they still lived in residence then and had all the rules and regulations that were common in the late '60s and early '70s....Culture differences were not really apparent in any way.(K1-3)*

Speaking of her experience with Aboriginal people in her hometown as she was growing up, Katherine said:

*I...was aware that there were Aboriginal people around but they...were, like, invisible. And when I go back now and I realize how many Aboriginal communities there are around there....They certainly were invisible to me...and they shouldn't have been because they were there. They were everywhere. But they just weren't part of the mainstream and...I don't remember ever talking about them in my family. I don't remember school having Aboriginal classmates and I don't remember any issues associated with Aboriginal people. They just-- they were there and we were here and that was kind of it....It's just that they weren't considered part of mainstream society and so they didn't really...come into your line of thinking...I never remember feeling any prejudice toward Aboriginal people. I just didn't see them as part of mainstream society.(K1-8)*

The Aboriginal community was invisible to her in her youth, despite its presence in the geographical community. Because Aboriginal people were not visible within the social structures, such as school, church and local neighborhoods, they were not part of her social experience.

*I then went to public health and in public health I did have some people that were different cultures but they were still primarily European....The majority of people I had that were not from Canada originally were Italian. And another elective I had taken in university was Italian as a*

*language.... I guess the one thing I remember learning from that was even attempting to use their language gave you a door in to interacting...with the clients in the community....The fact that you attempted to use their language was a really good thing. It made them welcome you right off the bat and I remember thinking at the time, isn't this something....But I remember thinking about that at the time and thought, boy, you know, if you do attempt to learn a little bit about what people's background it does make a difference. (K1-2)*

It was not until she encountered her first Aboriginal student in nursing education that she began to understand the experiences of minority populations. Her initial experience with an Aboriginal nursing student occurred when she was teaching in her first teaching job at the hospital school of nursing.

*...I do remember...one of the first native graduates from the school....We made special arrangements with her community and a group of people that were supporting her to get nursing education and she was from a very remote Aboriginal community in the north of the province. And she came down to XXX to take nursing at the XXX Hospital. I remember her well....She....stood out because she was totally different and she stood out just because of who she was....She seemed as kind of an anomaly so, again, we were just sort of flying by the seat of our pants but I can't imagine that she couldn't have felt very alone....It's not that she wasn't supported but that she really had no support system available to her for times that she wasn't in school...She did finish the program. I think she took longer than the two years and then she did go back up to her community....And I always wondered what her experience would have been like. But that was something very unique and sort of, at that time, considered very forward thinking that the School would have taken that on. (K1-4)*

The reaction of nursing faculty to the introduction of pre-nursing support (Access) programs for Aboriginal people at the community college where she now works was intriguing to Katherine.

*When the Access program first started, everybody was wondering...was this just going to be...a rubber stamp for people not to have to meet a requirement or whatever. But the director of the program at that time was absolutely committed...that the people that were brought into the Access program would be well educated and would meet the requirements before they got into nursing. And that they would keep contact with them and support with them for the four years that they were with us....She totally believed in what she was doing. And she expected high achievement from her students in Access and demanded it. (K1-6)*

The stories told by Katherine about the suspicion of faculty members toward students from Aboriginal backgrounds echoed the stories of tension and conflict that Mark and John both related in their attempts to increase diversity within the profession.

Katherine shared stories of the experiences of diverse students where she worked, and the supports that are provided.

*We have a cultural diversity department. And the head of that department is, again, a very strong committed knowledgeable person. And so we worked with her and had her come and do several hands-on workshops with us on dealing with some of the different cultures that we had and what some of the trends were and what we might be expecting. And she also works with students and says, this is what taking nursing education in Canada is like. And this is where you will probably kind of have struggles. And she's very, very forthright with them about what is a cultural issue that they have...a right...to see addressed in a certain way. And other things that are adaptations that they simply have to make. (K1-15)*

An incident with an immigrant student demonstrated for Katherine the potential for cultural misunderstanding that exists in nursing education, and also described successful interventions to address these misunderstandings.

*We had one incident a couple years ago where there was a gentleman who...was from an African country.... And he was struggling in clinical practice very badly...His clinical teacher was...a good, gentle warm person who no student ever felt uncomfortable with. But she had high standards and he simply wasn't performing and she was being frank with him...that he...needed to make changes. And as time went on, he didn't seem to be able to make them and she [the teacher] said that he...wasn't going to be able to pass this course at this time. He was going to have to repeat it. Well... he made... a comment about, "I'm going to end my life," or something like that. Whatever he said from the teacher's point of view was a suicide threat. And so she proceeded, as she would have been taught...if you sense that there's a suicide threat, you do... all the procedural things that we would expect somebody to do in a circumstance like that. Well, what ended up happening is that...the things that she did, he found humiliating and he went to the cultural diversity office and said that this teacher had told people...that he was a suicide threat. And he was ashamed and embarrassed and very angry that something like that would have been said about him. So...we worked together and she did a really good job of getting this student to explain to the teacher that using a phrase like... "I'm going to end my life," in his culture that it wouldn't be uncommon for people to make a statement like that. But that ending your life in his culture was such a deep taboo that...anything that suggested that somebody...was actually going to do that, was a shameful thing. But the other good thing that happened was that the diversity officer was able to work with the student and say, "Look, in our culture when someone says these kinds of words, it means...that you are threatening suicide. And the teacher has a responsibility to proceed in this manner. So you need to*

*understand that some of the choices of words that you use in our culture are addressed this way.” And actually the whole thing turned out really well and the student repeated the course and passed....But it was one of the incidents that I kept remembering, there’s a perfect example of a relatively innocent situation. There was certainly no intent on the teacher’s part to do anything that would be deemed culturally insensitive or racist but it happened. So we really, really rely on the diversity officer...to get us out of jams when we see a situation happening that we feel...we’re missing something and that...the student...is interpreting it in a way that’s not meant. (K1-16)*

Katherine’s understanding of the experience of diversity stemmed from her ability to relate authentically to her students and her colleagues in situations such as the one described above. She described the difficult experiences of her own students, and the experiences of Aboriginal colleagues and friends, and was genuinely distressed by their experiences of exclusion.

Perhaps because of her particular job, Katherine’s view of difference was largely related to ethnicity and culture. Her leadership was focused largely on cultural and ethnic groups, and not on others who experience diversity, such as people with disabilities or lesbian, gay, bi-sexual and transgendered individuals. While she talked about the imperative of creating nurses who could understand the needs of the populations they served, her approach to diversity was much more a pragmatic one based on increasing opportunities for participation, than a moral one, based on lack of fairness, as evidenced in the stories of Mark and John. This may also have related to the fact that she had no personal experience with being seen as different, as had both Mark and John.

It was the effect of her friendship with Aboriginal colleagues that changed Katherine’s understanding of the experiences of minorities in Canada. She spoke of her relationship with an Aboriginal nurse colleague who she had met in the 1980s.

*...It’s the first time I ever had somebody that I would say was a friend who was Aboriginal. And so she was a very big influence on me in terms of*

*seeing Aboriginal people in more than a...one-dimensional way. She was a real Aboriginal person who was part of my life. (K1-34)*

The second was also an Aboriginal colleague.

*The other person that was a huge influence on me was a woman...that used to be in our Access program and she's retired now. But she was the first native nurse to graduate from the XXX School of Nursing...in the '60s probably...She tells amazing stories of what it was like to be an Aboriginal student and...how some of the patients treated her. And how some of the other nurses treated her when she was going to school....She talks about one of her rotations...on...what then they had called the private ward where...the wealthy could go and they got...silverware and all that kind of thing. And she remembers having to go there and being really looked down upon by both the staff and the patients while she was there. And she remembers being made fun of because she had never seen a pat of butter before... and so she's having to set up a patient's tray. ...It had to be set up sort of like a dining room, I guess, and she had never experienced a lot of these things or even some of these utensils. And she said she was so mortified because everybody made such fun of her.... And those things were burned in her brain...It wasn't, like, she had five or six other Aboriginal students that she could talk to about it after. She was really... on her own. (K1-38)*

Some of the experiences of her current minority students in their nursing programs greatly distressed Katherine.

*...Some of the worst incidents we've had here that deal with racial issues are between students. Very, very disturbing....We had one incident where a student was talking in the hall and students were there including an Aboriginal student. And this student was going on and on about Indians and about she lived here and they were all drunks and they were all this and... the Aboriginal student was so offended. She came forward right away and, of course, we addressed it.... And she was disciplined and...a*



*letter went on her file indicating ...that she needed to get some cultural sensitivity training and that we wouldn't allow...any more comments.(K1-41)*

She stressed the importance of multicultural experiences for students.

*I think that we're going to have to...make more of an effort for providing students with clinical practice experiences...where culture is a major component of what's going on. Talking about maybe international...clinical experiences, exchanges, working with particular communities...maybe nursing electives that could be provided....If it involves international exchanges, if it involves working with a particular cultural group within the community, the exposure to diversity has to be better for nursing students. (K2-37)*

Multicultural experiences would reduce the incidence of Othering and marginalization in nursing students, from Katherine's perspective. Katherine talked enthusiastically about the College's active history in working effectively with Aboriginal and immigrant students.

*In the 80's the College started an inner-city nursing program... designed for Aboriginal and immigrant students who did not meet the ordinary admission requirements and had academic need and had geographical need and other types of needs....And a program was designed, a pre-nursing program, that involved completing any necessary English, science and math high-school credit...And from then onward, we have always had the Access program. (K1-4)*

She talked of the importance of creating a normalized presence for Aboriginal students on campus.

*What good thing came of that is that as Aboriginal access, it became the norm, then people got used to the fact that there were always Aboriginal students in nursing...One of the things that started to happen, of course, as we got more and more Aboriginal students was that we, then, realized that we really needed more....support at the faculty in terms of understanding*

*what these particular students needed to be successful, what did they need that was different than the way we handled things with other students and...we needed to make clear [ that the requirements we had for them ] would not be different than what was for other students. So we had workshops. We worked together as teams. We had students talk to us about...how things appeared to them and the kind of things that might be more helpful. The other thing that we really got used to, and I think this is one of the best things that we ever got used to here, was the idea that it was okay if it took you longer than...the prescribed length of the program to actually be successful and that if you have to repeat a course or whatever, that that wasn't considered a negative thing. We have learned that because the Access students often come with lots of issues outside of school, that it's not unlikely that they may have to repeat a course, they may fail a course, they may take a leave of absence or whatever, and that's just considered normal...And...there's nothing wrong with that and that's the way it's going to be. (K1-7)*

*...And then as we got into the '90s, we had already been working heavily with Aboriginal students for many years and then the influx of many different cultures through immigration started coming forward. And then we had other situations to deal with, some that were similar to working with Aboriginal students and some that were different....So right now for me, it's the norm. None of this is the exception anymore: it's the norm. (K1-7)*

Katherine's action in her organization promoted understanding of the experiences of diverse people, through diversity workshops, curriculum development and the creation of an inclusive cultural diversity committee. She also identified the importance of supports for diversity such as the diversity officer, who acted as a cultural interpreter and bridge between cultural groups. She also ensured that there were policies to deal with the conflict that arose in multicultural groups, and that they were enacted in a way that supported minority students.

Katherine had strong messages to the nursing profession about diversity and inclusiveness.

*...There is no possibility of becoming a sound nurse without being able to function well in a diverse situation....Dealing with different cultures and their needs and so on has to become second nature....The profession of nursing is the first line in terms of healthcare providers and...we...have a leadership responsibility of demonstrating diversity and cultural awareness.... I just don't think that...we can be the nurses that we need to be in this day and time without having that as a part of our professional expectation, our professionalism, our responsibility as a profession. (K1-45)*

Katherine, unlike Mark and John, felt that the profession has made significant progress and positive efforts to address cultural diversity within its ranks. She challenged the profession to view cultural competence and inclusion within the profession as the norm, not an add-on. She was comfortable that this was the reality in her environment.

Pragmatism drove Katherine's approach to the issue of building opportunities for students from diverse backgrounds.

*...We have to be able to provide people with different cultures ...the same opportunities as we have. And we have to learn how to do that, you know. (K1-32)*

Like both Mark and John, Katherine indicated that increasing the participation of diverse groups in the profession does not occur without conflict and tension. She spoke with some sadness of her first experience of personal conflict with a student from a minority background.

*I remember my...first experience that I had with feeling that I had been hurt or burned by somebody...This particular situation was very early in my years here. I think that's why it stood out because I hadn't experienced anything in my previous job... that would have prepared me for this particular situation...I had an Aboriginal woman in my group who was probably in her 40's or 50's...and she had been in the program for*

*some time.... I knew a little bit of her history and that she had failed A & P [Anatomy and Physiology] a number of times and that she was really struggling. So as time went on and I worked with her....When we talked about different things...her answers were sound. And I thought why is she doing so poorly on tests? Because at that time we had multiple choice and short answer tests a lot...she would always do very, very poorly on the short answers and yet I knew that she should or did know that. And so I was young and thought I'd like to do something. So I spoke to the team that we had and I said, "You know what? She knows this stuff. I think it's the testing and her ability to put it in writing on a short answer question that's throwing her off. Would you allow me to give her those questions orally and I will write down what she says to me." And so they agreed. So she would write the first part of the test, the multiple choice, and then she'd come to my office and I would read her the question and then she would answer it and I wrote it down. And she did much, much better. She did know.*

*And then she...was taking another course that I had some involvement with and she really struggled in that course....I had spent hours and hours and hours with her helping her but she simply could not pass the course....She appealed....And then I had to come and explain...why she'd failed...She had somebody with her that had been helping her, tutoring her... as her advocate. So they presented this situation and basically they said that the reason that she had failed the course was that I hadn't helped her enough and that...it was because she was an Indian....That I was racist and that was the reason. I remember going home and crying and thinking, how could they possibly say that? I did so much that I thought was helpful for her. And I was angry and I just remember thinking, why did I do all that? What was the point to that? And it was devastating to... anybody to apply that kind of label to me 'cause it didn't fit my nature in any way. And I remember being really, really hurt and after that, very*

*careful, nervous, because I thought, you know, if this is what happens then I'm just going to go by the book. But as I got involved more and more-- I see things and that sometimes it's just an element of desperation. That people will necessarily...choose to play a card that they have to play and I did not feel that she ever truly felt that I was racist. It's just that she couldn't think of anything else to say and...she had that possibility that that would be helpful to her. But I remember being really burned by that.*  
(K1-27)

Katherine's experiences and her ability to establish effective relationships allowed her to see beyond the obvious in this situation, and to explore the power relationships at play. This allowed her to develop and share a perspective which might otherwise have been absent, and might have led to her deciding to simply give up assisting minority students because the risk of being called racist was simply too high.

In this situation, Katherine learned something of the desperation experienced by minority students when things go wrong in their integration experience. She also commented on the inevitability of conflict when increasing the diversity within the profession. Learning to recognize a student's accusation of racism as evidence of the student's desperation in the face of potential loss of a dream revealed an ability to see such interaction in relation to power structures, rather than as an interpersonal issue. She was well aware of both the responsibility and the accountability of educators with respect to the tensions between the need to support students who are struggling and the need to protect the public from unsafe nursing practice in the long term. She spoke of the impact of this accusation of racism experience on how she addressed conflicts between minority students and nurse educators at this stage of her career. In talking to the instructors

*... I said, "You know what? Why don't we start out by saying, 'Let's have a look at what happened and see if there's any elements in there that culture has made a difference in the way the student has interpreted things. Don't go with the thought that whatever you did was racist. Just let's hear what happened and see... if the student had any reason to*

*interpret that in a meaning that you didn't intend.''' And often that...helps. (K1-28)*

For Katherine, it was critical that educational administrators build a critical mass, a community of diverse students, faculty and supporters who can strengthen and inspire each other.

*I really, really would like to have more Aboriginal faculty and immigrant faculty. I think that would make a huge, huge difference. Right now I have two staff that are of Aboriginal heritage and they are incredibly helpful....I have ... just hired a new instructor...from the West Indies and she's just a great teacher....If I could just get a few more faculty members that come from different cultures that have the educational requirements to teach, it would make a big difference. I know that if we had some more Aboriginal instructional staff that we could do a better job working with Aboriginal students. And white students... working with an Aboriginal teacher, you know. But it's a struggle. (K1-30)*

*And I think from a student perspective, seeing Aboriginal faculty gives them a whole different sense of how important culture is, actually, to the faculty. You can espouse a lot of things but...if it's visually clear that you are actually...walking the walk, it makes a big difference. (K1-30)*

Katherine was clear in her commitment to creating multicultural communities in her institution, including students, support staff and programs, and faculty. Her desire to increase her diverse faculty in order to provide visible, positive role models, and her creation of a broad-based diversity committee revealed a potentially celebratory view of diversity, where opportunity could lead to the formation of communities of difference. Her desire to create a critical mass of students who were motivated by role models and supported in their peer groups painted a potential for a very different student experience than the experiences of the students described in the literature in Chapter Two.

The importance of *active* support for diverse students was not lost on Katherine. Like Mark, she knew that passive solutions simply weren't enough.

*Well, what I found here is that...we simply had students that were so diverse, that...you couldn't just muddle through anymore trying to pick up things....One of the first things that we did is I suggested to staff that we have a cultural diversity committee of the faculty. And... I said... I wanted students on it, and I wanted representative students from a variety of cultural groups. I wanted gender taken into account and made sure that all the major elements of diversities were represented on the committee. And then the goal that I gave the committee was to....develop [a] mission statement and look at some of the things that...the school has to do to be inclusionary on a day-to-day basis...We had both male and female immigrant students. We had a representative from Asian students, African students, Eastern European, probably Philippine.... And then the people that were on it from the faculty were selected by the faculty. And they met...several times throughout that year and put together a proposal for us on how as a faculty we might address the issue of inclusiveness, what the students felt were some of the biggest areas that perhaps faculty needed more education on. (K-14)*

When asked about the commitment of nursing as a profession to increasing diversity within, Katherine, unlike Mark and John, was strong and optimistic in her belief that the profession of nursing had embraced increasing diversity.

*Well, from what I can see here, I think that the profession of nursing and nursing leadership in institutions...work very hard to address cultural diversity and to try and get staff educated and consulting when they need to. At the XXX Hospital, the Aboriginal workshops are a requirement of...orientation because of the huge population of Aboriginal patients. And they're excellent and they're thorough. And...you must attend. It's not an option. (K1-36)*

However, she acknowledged that there are still diversity challenges within the system.

*...I hear these stories...about how terrible this nurse was with this patient who couldn't speak English or couldn't...do this or that and just ran roughshod over them. And so it makes me wonder. And then I think, well, you know, if it's not the majority maybe you have to be careful that you don't sort of take one incident and decide that that's... sort of the norm. Because I don't think it is. But it's still a little bit surprising some of the stories I hear about the blatantness of some of the behaviour that people still do in the profession in this day and age. Quite shocking, actually.*  
(K1-40)

In summary, Katherine's view of diversity was more focused on ethnicity and culture than were the views of the previous participants. She was inherently more positive and upbeat about the profession's accomplishments than were Mark and John, even though she admitted, sadly, that incidents of racism and exclusion did still occur. Her leadership role allowed her to implement positive, active policy initiatives that supported inclusions. Unlike Mark and John, she had no first-hand experience with being viewed as different. Possibly for this reason, her views of the importance of inclusion were more pragmatic and less moralist than Mark or John.

### ***Leadership***

Katherine explored her views on leadership, including circumstances that brought her to the role.

**Early influences leading to leadership.** According to Katherine, her tendency to lead started at an early age.

*When I look back, I was always as a child... the one that said, "Okay, well, I'll organize it." I was raised with a father who worked his way into a leadership position and had some of the same attributes that I have in terms of he was very well liked and he seemed to be able to read people well.* (K2-28)

In Katherine's view, the influence of her undergraduate nursing professors at the school of nursing she attended was instrumental in her development as a nurse and as a



leader. Of one faculty member who went on to become a prominent nursing leader in Canada she said:

*She was my mental health teacher and she was very young and...very futuristic...She was the first teacher that had us call her by her first name. And she had amazing ideas and I remember thinking, oh, my God, is this okay? Are you really allowed to do this? [Laughs] ...But when I think back about the profs that I had there, many of them stay with me to this day, some of the ideas that they had and they've shared with us. (K2-21)*

Katherine's story about her nursing professor demonstrated the power of educators as role models in challenging the status quo within the profession. This small act of a then-young educator, suggesting that students call her by her first name, pushed the boundaries of the profession and allowed the participants to entertain the possibility of a more supportive, less formalized and power-driven relationship between students and professors, rather than the highly structured, hierarchical, militarized relationship common in nursing education in the 1960's. The symbolism of that act remained with Katherine 40 years later.

### **Critical Leadership**

From Katherine's perspective, leading critically required being able to deal with conflict, understand power, influence developments within the profession and above all, to laugh, especially at one's self.

**Leadership and laughter.** Like Mark, Katherine maintained that a keen sense of humor was essential to leadership. Humor for her was a reflective practice, gently challenging others to see beyond the tension of the moment, and often revealing, in a supportive way, the inherent absurdity of current practice. Humor built bonds between Katherine and those around her.

*I also have a very good sense of humor and I've cultivated that.... I've learned that that's a really helpful skill for me to have. I can set people at ease right away and, you know, if you can't see the ludicrousness in some of [this stuff] you can't survive. (K1-34)*

**Dealing with conflict as a leader.** Like Mark and John, Katherine saw dealing with conflict as an inherent part of being a leader. Katherine talked about the leadership lessons she learned from situations of conflict during her career. She spoke of learning about perspective, of separating her view of her personal self from her tasks as a leader.

*I did work one time for someone who... was easily threatened and I remember thinking, you don't get much out of people or you don't get much truthfulness out of people if they feel like if they tell you the truth, you're going to yell at them or...tell them they're wrong or tell them it's not their job to say that or whatever. So what I learned from that person was that I need to be able to shut my mouth and listen and ... [I] cannot take things personally....If you as a person and being a leader is one and the same thing, you're going to get into emotional trouble. So I remember her and I remember thinking many times ...whoa, don't think that's a good way to talk to people...if you want them to be...coming to you and talking to you about their ideas. (K2-19)*

Rejecting the bullying and control tactics used by some leaders, Katherine spoke of the importance of building alliances in order for those involved to see the vision. She described a former program director with whom she worked, and her approach to conflict.

*She didn't much care whether you liked her or didn't like her.... She would get what she wanted because people wouldn't want to argue with her, right. So we'd come out of meetings and she'd say, "Well, that went pretty well." I said, "Are you kidding, Ann? If those people had had shotguns you would have been dead." ... I don't tend to operate like that. I tend to try and...keep people on my side and use logic that way. However, one of the things that she told me when I got this job was her read of me and what she said to me is, "You have to remember two things. It's not a popularity contest and you have to toughen up." And I think that that was really true. I never forgot that she said that. And I did have to*

*toughen up considerably because sometimes things are distasteful that you have to do. (K2-18)*

Katherine, like other participants, identified a tendency in herself and in the profession to avoid conflict. Ultimately, though, she knew that leaders deal with tough decisions. One of the things that she learned during her time as a leader was the importance of not shying away from the difficult conversations that come along with those tough decisions.

*And I think one of the things that I have had to learn is ...not to let things fester and ignore them until you can't ignore them anymore.... I have had staff issues where I got complaints on and off ...over the years from different groups and...nobody was necessarily that specific but had I used my head the themes were the same. And so by the time I actually addressed it with the faculty member and said, "You know, I've been getting these comments for years," it was a very messy situation.... In retrospect, I know that I should have handled it differently, that I should have dealt with the complaints right off the beginning....And not leave things until you can't leave them any longer. Because that never works out well....Yeah, and I realize also what happened is then that the person that I had to deal with was devastated in a way that they might not have been if I had laid it on the line right when I first heard, you know, 'cause when you say to somebody, "I've been getting these comments for years." That's a pretty devastating perspective for someone and saying, "Okay, I've heard this. Do you want to tell me about it?" and that so that then if it comes again I can say, "Well, you know, now-- I've heard this again," versus, "I've heard this 20 times in the past two years and I can't stand it any longer." [Laughs] So if I had to pick my own biggest fault, that's the one that I see, is dragging my heels in dealing with interpersonal stuff with faculty.... I like it better when people just behave themselves [Laughs]. (K2-32)*

Katherine concluded her discussion of conflict with a statement about the importance of taking action toward a goal, even in the face of opposition. Despite her best efforts to bring people in to her vision, sometimes she had to act in ways that some of her colleagues did not like.

*And I guess I'd say another thing is that you need to be prepared that at any given time, someone is not happy with you or something you've done. The idea of perfectionism being associated with leadership is not a good thing. You are never going to please everyone and there's never going to be a time where someone is not concerned about something you're doing. And you just have to live with that. (K2-36)*

In her straightforward way, Katherine indicated that leadership was not a popularity contest, that it was the responsibility of a leader to make tough decisions, and that difficult decisions inevitably engendered some unease in the followership. If the decisions were based on ethical principles rather than self-interest, she was comfortable with that discomfort. Such creative tension allowed for dialogue and reflection which increased understanding in the long term.

**Having influence as a leader.** The key to making those tough decisions was to reflect on the principles at stake. For Katherine, being able to act on principle was a key part of leadership. Katherine acknowledged that it was important to her that she be in a position where she can act on principle and thereby effect change in the profession. She had a strong commitment to the ethical foundation of the profession, and wanted to be where she could influence the development of new nurses who understood and embraced this foundation. Her desire to influence the development of the profession came from a respect for the unique ethical views and approaches of the profession, and the important role that it played in health care and the welfare of society.

*Yeah, I feel pretty strongly that...I want to see nurses clinically sound and also have the ethical qualities that are necessary. And I want to be a position where I could influence where nursing was going...I try to make sure I know what I'm talking about...and I'm good at it.*

*I like being in a position where you can have some influence over what happens with the profession. (K1-12)*

**Understanding power.** She was clear that her position was a political one, and that power and influence were important aspects of her role.

*And in the sense of nursing, I don't know how you can be an effective leader without some political astuteness. Different types of politics, you know, you need to know your own institution's politics. You need to know the general politics of the profession at the time....And you cannot lead in nursing without being aware of what the political status of nursing is in the general scheme of life. I think you need to be aware of political power and respectful of it. But not sit in awe of it....*

*So I would stop and say if I've learned nothing in this job I've learned politics. (K2-10)*

She expressed annoyance with the nursing profession's historical distain for political action.

*We used to view politics as distasteful and beneath us. And so we were able to...stay in our little cocoon. But I think those times are long gone that we have to be able to speak out and speak up and be prepared for controversy and speak about the profession in ways that those outside it can understand. And it's a matter of professional survival to me. And as a leader, I absolutely have to have that skill. (K1-10)*

Leadership, from Katherine's perspective, required a sophisticated understanding of the power structures within institutions, professions and society. She advocated developing a vision based on a clear understanding of current and future political influences. She used her dealings with the director of the funding agency that funds university and college programs as an example of the need for political astuteness, and strategic approaches.

*Any time we had an opportunity to talk together I would make my point (with my Dean's blessing) by being honest with him about our view versus his view...*

*.... I would say, I know that you have to make these kinds of decisions and...here's the story. And is there somehow...we can mesh our two needs, and that kind of thing. And we got along very, very well... So you have to play politics and you have to learn how to...say things that aren't nice to say in a way that doesn't sound threatening or overbearing or whatever. (K2-13)*

Of leadership and power, she indicated

*I'm not real big on the word "power" but I'm not naïve either. There is power attached to any leadership job. And I have a tendency to get annoyed with people who are overawed by the power of the job. So you know that they're just telling you what you want to hear....I don't have a lot of respect for that kind of stuff. I just want to say, oh, knock it off.... I don't think I leave that feeling among people, so they can be pretty frank with me in a respectful way. But you always have people who are fearful of any power you might hold and you can't necessarily take that away from them even if you don't see yourself that way. (K2-20)*

**Leadership is about being good at what you do.** As with the previous participants, Katherine was confident of her expertise in the profession and as a leader. She stated, in a matter-of-fact way "I'm good at it".

For Katherine, critical leadership was about using humor, addressing conflict head on, not taking things personally, building alliances, understanding power, and acting on principle.

### ***Transformative Leadership***

Transformative leadership, from Katherine's perspective, required passion and vision.

**Vision: Leaders need to know where to lead.** It was not simply enough to lead, in Katherine's view. It was important to have a clear vision of where she intended to go. Leaders have to be visionaries.

*The leader has to see the whole. They have to see, well, in my case I have to see program wholeness. I have to also see institutional wholeness. And I have to see professional wholeness....*

*Yeah, my responsibility is to see the whole and ensure that people that are having difficulty seeing the whole, that I help them with that. (K2-9)*

For Katherine, it was not enough for a leader to have an awareness of the current environment.

*...If you're going to be a leader, you have to look outside your own sphere....And the other thing you have to be is futuristic....I have to be thinking all the time about... what are things going to be like in three, four, five years. And...what do we have to do to position nursing best for the future. (K2-14)*

Like John, Katherine believed that the front line staff--in her case the educators--were too consumed by everyday activities to be aware of the environment.

*The staff, for the most part, are dealing with their day-to-day responsibilities. There's classroom teaching, clinical teaching, projects that they're doing or whatever. And they don't have a lot of opportunity to sit down and say, well, I wonder what's going to happen in three, four years from now or what we should ...be doing. (K2-14)*

Thus it was a very important function of the leader to be able to describe the horizon to the faculty and to lead the development of plans for the future that address the needs of the public in that future. An important aspect of having vision, from Katherine's perspective, is living with the ambiguity that is inherent in moving toward that vision.

*...A lot of working as a leader involves being able to work with a variety of personalities in a professional way. You have to be flexible and you have to live with lack of closure. That leadership is not about being in charge of a project or something and just getting stuff done. It's about seeing that things are moving forward versus, I mean, there's never a day that I go home where I feel like I finished whatever I was supposed to do that day. (K2-35)*

**A passion for leading.** What was necessary to fuel a leader through this ambiguity and lack of closure was passion. Katherine was fueled by a passion for nursing, for its clients, for her staff and her students. Katherine spoke with quiet pride of her choice to enter nursing...

*... I've never been sorry I did that so...I never had any blazing desire from being a little girl that I wanted to be a nurse. But I've never been sorry.*  
(K1-11)

...and with passion about her students and colleagues in nursing education, and their impact.

*And I loved, loved, loved working with students...in clinical practice....  
Sometimes I still miss that.* (K1-12)

A strong commitment to and belief in her colleagues was evident throughout our discussion.

*I'm not naïve but for the most part I think that people just want to do a good job. That doesn't mean that...there aren't people who are suspect in terms of what they're doing in any given place. But the vast majority of people really want to do well and their motives for coming to do the work are that they really care about students and... they'd like to influence the next generation of nurses. And that their motivations are honorable in terms of why they choose this particular part of nursing.* (K2-27)

For Katherine, it was this positive view of people, her passion for the profession, the society it served, its members and soon-to-be members, and her clear vision of the kind of profession she wanted to see that drove her leadership for transformation of the profession and of nursing education.

### ***Educative Leadership***

Katherine believed that leaders needed to educate others through sharing of strategic directions, role modeling, advocating, and creating opportunities.

**Leadership as strategy.** Speaking of the importance of being strategic as a leader, she said:



*... I suppose it's part of politics, too, but I think to be a good leader you need to build support and bank goodwill. So-- how can I put it? Everybody has their opportunity ...at some point to be the golden child and when you have that opportunity, if you behave like a brat, people remember that. So that when you're not the golden child and you need others, they remember what you were like....The relationships that I create with the people above me and other partners at the college are important for times when we need help....So any opportunity I have for nursing to help out somebody else here at the college or if I have a workshop going that I'm putting on for my faculty and I think somebody else might be interested, I invite them. I work hard at getting along with the people above me.....And if you're going to have battles with people, you better pick them because-- it better be worth the battle. So I think banking goodwill on behalf of the people that you lead and building support is an important part of leadership as well. (K2-13)*

An important aspect of being strategic was knowing when to move forward on contentious issues, a process that required “pulling rank”, as Katherine called it. Katherine ruefully admitted that there were pitfalls to an inclusive leadership style.

*Okay, I'll tell you what my less successful things have been. They are things in which I have...waited too long to intervene in situations. Meaning when I talk to you about how I want everybody to feel that...they have a say... I have had circumstances where I've carried that to the point where a decision simply didn't get made because I wasn't able to see when it was time to say, “Okay, you know, we've talked all about this. We've got everybody's opinion. Now we have to make a decision and I have to make it.” And sometimes I've just let things go on and on till it just, you know, we got lost in verbiage and opinions and so on. And it wasn't the right way to go. So I have had to really learn how much discussion is enough and when I just pull rank. And what I have learned is that there are very, very, very,*

*very few circumstances where pulling rank right off the bat is going to make for a good decision that people can live with. But finding that balance between how much discussion is enough, because we're never going to agree on this, versus, well, I'm the chair and we're doing it this way so-- I have found that I've been caught a couple of times. (K2-31)*

For Katherine, inclusion was therefore a delicate balance. There was little value in involving people in decisions they did not have the authority to make. For Katherine, this was a difficult lesson.

**Leadership as advocacy.** The importance of role modeling and advocacy in leadership did not escape Katherine.

*...Letting faculty and staff know that I have that expectation of us in terms of working with students, working each other, developing curriculum and so on....And my faculty know that if there's anything that they want to do in terms of a project, community involvement or whatever, that involves cultural diversity...that I will totally support them, financially or any other way if I can. So I see the leadership as role modeling and...putting your money where your mouth is. (K2-30)*

As a leader, Katherine saw her role as an advocate.

*But...I have to encourage my people to change if they need to...And it's even protecting them from change if I can, if I don't think it's a change that's helpful. Sometimes I have to take that on as the chair to say, no, nursing's not going to participate in that. Because, you know, it's just not the right time for us or whatever. (K2-15)*

**Creating and recognizing opportunities as a leader.** Leadership, for Katherine, was about risk-taking.

*So-- you have to be able to take risks and I guess... the guide that I tend to use is what's the worse thing that could happen? And based on that thinking, then, decide if something is worth risking. (K2-15)*

From Katherine's perspective, this risk-taking role involved recognizing and weighing opportunities and not being afraid to put forward new ideas or take on new roles. She found that she had this approach, even early on in her career.

*I remember when I worked in public health nursing I had a couple of opportunities to start new programs and ...and I had to sell them...to the powers that be. And I remember finding great satisfaction in that, that I seemed to be able to sell my ideas and that people were prepared to take whatever risk was necessary to put them into practice. (K2-29)*

She talked of her ability to move forward when opportunities presented themselves in her current position as a director at the college.

*...I really like to...make it clear how much we have addressed immigrant and Aboriginal issues in terms of programming that's needed. That...if somebody asks us and we feel it's something we can fit and that we can finance, then we'll take on special programs for...a certain immigrant group or particular Aboriginal group or any of those kinds of things. So...people know that the nursing department at XXX is very open to any kind of thing related to working with culturally different groups. And...because my name is attached to the department that... I have that reputation. We tried very hard to be very careful to only turn down things that we legitimately simply can't take on. (K2-29)*

Katherine's career was largely about recognizing and creating opportunities. She recognized the opportunities afforded to her early in her career to move from a hospital-based program to the college. She recognized the possibilities in the college's innovative role in nursing education at the time of her move. She was proud of the college's history of innovation, and spoke with satisfaction of the tradition under her leadership in the nursing department of saying "yes" to all innovative projects promoting diversity. The willingness to take risks and move agendas forward was consistent with her pragmatism, but also with her commitment to change. She also recognized that with a willingness to explore the possible came the need to be comfortable with uncertainty. Ambiguity and lack of closure were important aspects of her leadership.

For Katherine, strategy, role-modeling, advocacy, risk taking, and creating opportunities were all important aspects of leadership.

### ***Ethical Leadership***

Being a leader required Katherine to act ethically in her dealings with people.

**Ethical leadership requires authenticity.** Katherine required authenticity, honesty and directness in a leader, and expected the same in her colleagues.

*...For me as a leader of this nursing department, I feel my biggest responsibility is to...define reality, to be as honest and open and frank with staff and others as I can, with what is happening, where things are going, that kind of thing. (K2-9)*

*[I] don't mean a\*\*-kissing. I mean, being present and being honest without being smart-alecky or being too much of a yes-man, kind of thing. I value honesty but then nursing does. I find that dishonesty really upsets me, not just because it's a lie but that people would choose that in this profession. (K2-13)*

For Katherine, creating an environment where openness and directness was the norm was a significant part of leadership.

*So I try to set an atmosphere where...people don't feel a need to be dishonest about the way things went, that somehow there'll be a consequence that they can't live with. (K2-27)*

That honesty extended to admitting when things had gone off the rails.

*...I apologize to people if I feel it's necessary. If I feel I've made a mistake as a chair, I don't mean I grovel, but I mean, I'll say, "You know what? I've thought about this and I think this would have worked better. I think I made a mistake here." And I expect my staff to do the same thing. (K2-27)*

**Leadership and commitment.** Katherine was committed to creating an environment where it was safe for her faculty to be honest with her, to disagree with her and to challenge her views. She viewed these commitments as aspects of ethical

approaches to leadership. Like Mark, she possessed faith in the inherent goodness of people, and saw them as wanting to make a positive contribution.

**Leadership required listening.** Listening was an important aspect of leadership, in Katherine's view. While much of leadership was saying "yes" to opportunities, Katherine also recognized the importance of saying "no" at the appropriate time. Like Mark, she identified the importance of maintaining a strong bond with faculty so that she could recognize when they were not able to rise to a particular challenge that she was proposing, and when she should back off advocating such changes until a more appropriate time.

Katherine's leadership was embedded in an ethical approach to others that requires honesty, openness, and a willingness to admit to vulnerability. It was also based on a commitment to making these approaches explicit to those around her.

### ***Inclusive Leadership***

Katherine's story revealed a leader who was very involved with her colleagues, who was committed to teamwork, and who recognized the importance of collaborative relationships in achieving a leadership vision. Katherine described her style of leadership as one that was informed by the same egalitarian approaches that prompted her to act on issues of diversity.

*Well, I think the one value that I have...it's a value that operates here in the department and I kind of demand it and that's an egalitarian approach to everything. I'm not real big on hierarchy.... I don't...even like it [hierarchy] ....I find it offensive. So we have sometimes, for example, had trouble when we've had new staff who are used to a very structured system and they can't let go of that. And it simply doesn't sit. People walk into my office and say hello to me and if they need me they come....We don't talk to each other in terms of credentials....So we don't call people "Dr. this" or "Dr. that"... I've always thought education was super important. I like to get educated...I like to be around smart people. But I've never been able to buy into the value of formal hierarchical stuff.*

*...I accept that things have to be hierarchical for operational purposes. But they don't have to be hierarchical in that I'm more important than you. And I really feel strongly about that one....When I talk to people about coming here...to work... I'd say..., "You need to understand that we don't stand on ceremony here. That you're all part of this team and that you have a level of influence that's consistent with everybody else." (K1-31)*

For Katherine, inclusion drove her leadership approaches. Inclusion was both a process of maximizing people in decision-making, and a goal—a goal to increase the participation and success of Aboriginal, immigrant and low-income students in nursing education.

### ***Katherine's Story: Conclusion***

Katherine's views on leadership for diversity in the nursing profession can best be summed up by this comment:

*...It's incumbent upon the leadership in the profession to ensure that diversity is always a global consideration in nursing education...and practice. I think we have a responsibility to do more-- be leaders in terms of researching more in that area. We no longer live in a time where you can just give lip service to diversity.... It is part and parcel of nursing and it's just not an addendum.....And it means that many of the ways that we approach things may require some rethinking. And I suppose it's a similar theme to globalization, you know, we no longer live in our little insular section of the world. And nursing can't do that anymore either. (K2-36)*

Katherine exhibited significant success in her years as a leader at the college where she worked, in impacting the cultural make-up of the profession. While perhaps less explicitly transformative in approach than the first two participants of this study, and more pragmatically focused on increasing the participation of Aboriginal, immigrant and visible people in nursing education in her own institution than an overarching commitment to social justice, Katherine was driven by an overall commitment to

excellence in the nursing profession. She was clear that excellence could not be achieved by any profession without creating a nursing workforce that understood and represented the cultural diversity of its clients.

**Madonna's Story: You don't Fight Fire with Fire or It's All about Being "Us"**

Madonna was born in the Caribbean, and came to Canada as a young woman in the early 1970's. She prefers to be described as a black woman, indicating that her color is a significant part of her identity. She is currently the executive director of a not-for-profit-health care organization in a large metropolitan center in central Canada. She is the past president of various nursing and health care organizations, and is on numerous community agency boards of directors. She is also a part-time professor with a local university. A national nursing organization biographical commentary described her as having a gentle but strategic approach to issues of diversity, and an ability to connect with people.

Educated as a teacher, with a background in teaching at an infant school and primary school on her home island, her credentials were not recognized when she came to Canada. Her transcripts were evaluated as equivalent to grade 10 in Canada. She then began the process of upgrading her education. To support herself during the upgrading process, she took a job as a health care aide, and found that she enjoyed the work. She decided she would like to pursue nursing as a career. She discovered that she could be accepted into nursing in a neighboring province with a grade eleven standing, whereas the province where she lived at the time required grade thirteen. She promptly moved to pursue a diploma in nursing.

***Diversity and Inclusion***

Madonna talked of the early influences in her life that brought her to where she was currently. She described some of the barriers that she experienced in her efforts to increase her education and find a suitable job in Canada.

*I was accepted in a community college in the nursing program and that's where I did my nursing. I graduated ...but in Quebec, you had to have the French... I would pass the oral, fail the written, pass the oral, fail the written. I understood [this province] gave reciprocity for nurses...who*

*had completed their course work and had their diploma, but were waiting for... the French test. So I moved here...and was able to continue practicing actively nursing here. (Md1-2)*

In addition to her work as a health aide, Madonna had other experiences that inspired her to look to nursing as a career.

*I experienced my mom dying of breast cancer at a very tender age of 48 years old and the way I saw individual nurses coming in and caring for her... [I thought] this is what I'm going to be.... (Md1-3)*

However, Madonna also viewed her choice of nursing as a career as an attempt to gain admission to a society that had placed barriers in her path.

*And I think another reason I chose nursing, I figured that would be maybe the more acceptable profession for a black woman moving to Canada and trying to do something very, very different. It was maybe more of an acceptance, you know what I mean? (Md1-3)*

*You know, when...you don't look like people do in Canada or where you work...you feel you are treated very differently or maybe your perception is you are treated very differently. And then you don't get the teaching job because your qualifications have been downgraded to grade ten. So...you figured, you know what? Maybe taking care of patients is what I should be doing, because then that is an acceptable profession, that is a respectable profession.... At that time, as a young woman coming to this country, I was looking for a profession that allowed me to be me and deliver in a caring manner...not acceptance as a person, because I knew who I was, but as you adapt to a foreign country, you really have to look at what are some of the strategies you have to use to, number one, adapt, and number two, be successful. (Md1-4)*

Madonna learned early in her life in Canada that acceptance was going to require action on her part, and that she needed to be strategic in how she could move ahead in this society.



Following her graduation with a diploma in nursing, Madonna went on to complete a baccalaureate degree in nursing with a focus in community health, followed by a master's degree, again with a community health focus. Recently she completed the requirements for a doctorate with an emphasis on health policy and health education.

When asked what led to her success, she stated

*I think it had a lot to do with...attitude and not feeling second class. Because...I was brought up...to believe that I was equal to every human being and must be the...best. I have to be confident in who I am....So I think it is based on that self-confidence ...which I got from my parents.... I was from a family that at home, they would consider upper class....And there they taught about believing in ourselves, education is really the key, going after your goals and what you want...So...when I came to Canada, I always practiced with these tenets in mind, in a situation where I take responsibility for my actions, and if something doesn't go the way I want it to go, then [I] do not blame someone else, [I] just see what was my level of participation in that whole event...I have had failure in my journey to where I am today, but I have never let it be an obstruction. I have always let it be something motivating me to continue the journey. (Md1-6)*

*...When I was growing up, my parents taught me everyone is equal. You have to treat individuals as you'd like to be treated.... And that's where these values, I think, came from.... (Md1-19)*

Madonna's early influences, her parents and family, created in her a belief in herself, an expectation of hard work, and confident assurance of her ability to succeed. There was an expectation of success—not a punitive one, not a controlling one, but an expectation of success none the less. Those early influences instilled in her a confidence that allowed her to tackle new experiences with comfort and positivity.

For Madonna the expectation from her parents that she would achieve, coupled with support from them in the process created in her an attitude of achievement that drove her throughout her adult life.

While parents and family members served as role models and supports for her success, Madonna also looked to contemporary public figures for inspiration.

*I also look at people who are in the media and how they carry themselves. And sometimes I pay very close attention to my own people, you know. How they do things so that I could use them as role model[s] ... I will just watch what they do and based on what they do, I'm able to say...how I would approach that. You know, like, even Barack [Obama],... That also, to me, is role modeling 'cause I'm telling you, he must have stamina to be able to deal with what's going on. He must have stamina and he must carry himself very, very well. What I like about him also too, is... it's always about the issues, it's never personal, and that's what I have been taught. (Md1-21)*

This observation with respect to President Obama and his focus on the issues rather than the challenges to him personally demonstrated an important aspect of Madonna's approach to difference and to being treated differently. She described how she came to her current perceptions of what it means to be different in Canadian society. She related this story.

*So I remember my very first snowfall. On my way home, I fell in the snow and I didn't get up because I tried and I fell again 'cause...you have to know how to walk in the snow. And there came a police car, and [the policemen] asked me what was the problem and I said, I fell. So they helped me up ...and they said, "Could we take you home?" And I said, "Sure." Now I didn't know the stigma attached to going into a cop car for a black person. So here I am in the cop car, getting out of the car in front of our apartment and here comes my brother out of the apartment. Well, he says to me, "What did you do?" I said, "I fell"....When I reflect on that story, I think it's really all about adaptation. Would I go into a cop's car again? Absolutely. Would I be feeling stigmatized by it? Absolutely not. (Md1-17)*

Madonna was clearly undaunted by an experience that might have traumatized others in her situation. This “go forward” approach was a hallmark of Madonna’s successful adaptation to Canadian society. This positive approach was very important to her during an incident in her nursing education program that had the potential to negatively affect her view of herself and her future.

*...I was doing my baccalaureate and I was succeeding in the theoretical aspect of the subject and the course. And I went to visit a client with my teacher.... I went to teach a client about diabetes. When I got there, that client had lost her...best sweater and I made the assessment she could not really take in what I was going to teach her ‘cause she was focused on...[her sweater]-- and she was not a rich lady. (Md1-6)*

*I...was unable to refocus her to do the diabetic teaching and I chose not to do the teaching because I knew the patient would not be listening. Because to me... the first thing in teaching, if the person is distracted about something they’re not going to listen to what you have to say. (Md2-10)*

However, the professor who accompanied her on this visit did not agree with her assessment of the situation. The professor completed her evaluation following the visit, and told Madonna that she had failed the course, because she had been unable to get this client to focus on her teaching.

*So when we got back to my evaluation, the teacher said there was a problem with the semester, with this course. You may have passed the theoretical piece of it, but you fail the clinical....And I remember her saying that to me and I said, “Oh, well, maybe just an extension to redo an interview.” And she said to me, “That’s not an extension of the semester, I mean a repeat of the semester.” (Md1-6)*

Madonna was stunned by this, as she was well aware that someone in her class, who was white, had been allowed an extension. She was devastated by this experience, which she viewed as racism.

*So consequently, I figured, oh, you know what? There is something going on here and I don't like to call the "r" word..., but it was a difference in treatment. And that to me almost said well, just totally give up, Madonna, and I...cried, I did everything else, you think of suicide... because you're so embarrassed. And you think of running back home to the Caribbean, what am I doing in Canada? But then again, you know, I caught up myself, again always believing in, well, what's your part in that? What could you have done differently? And I had to repeat the semester, but you know what? That was the best experience. The professor who I had when I repeated that semester, she was respectful; she knew that I knew myself. She gave the feedback that she had to and she was there when I needed her....There's always a silver lining behind the cloud, so to speak. (Md1-6)*

This experience had a profound effect on Madonna and her future. While some people would have been bitter and angry at the unfair treatment, she reframed this experience as one of learning and growing.

*And...it made me re-learn. It made me reconnect. And I'm telling you, I will thank that professor if I meet her for contributing so positively, although at that time I didn't see it...And in the end I prevailed. Yeah. But I learnt a lot....But, had I not gone through that disappointment, maybe I would not be where I am today. (Md2-29)*

Summarized her response to failure, Madonna stated that failure could serve to inspire and actually strengthen one's approaches, encourage change and lead to better solutions in the end. Failure, while very difficult, was not to be looked on as an end, but as part of a process. An important part of her message was: don't be afraid; be upfront and out there; don't shy away from the difficult discussions, be part of those difficult discussions; make sure that those difficult discussions happen when they need to happen.

*I see my role as always walking the talk and demonstrating what I see it should be....But, again, I always think it's about people, it's about working with each other, and I see my role as being a facilitator. I see my*

*role as being an example and I see my role as being a supporter. (Md2-19)*

Madonna's experience of being treated as different occurred in her adult years, after she had come to Canada. Perhaps her strong sense of herself and her maturity allowed her to reframe some of the negative experiences to be positive learning opportunities. She espoused the belief that failure can inspire success. This reflected Madonna's positive outlook, her almost relentless optimism and her view that anything was possible. It was this driving optimism that made her such a positive spokesperson for inclusion.

One of the important reframing lessons learned in the failure of this clinical rotation was to not take the injustice of the situation personally, one of the messages addressed earlier in this narrative. Madonna talked about the importance of this lesson in a later experience where she experienced prejudice.

*...I was the executive director of an organization and...two white guys came to meet with me....So when they came in, they said, "Hi, we're here to meet Madonna XXX"...Right away the one guy looked at me and he smiled and the other one looked at me and figured, what? You? Anyway, I walked up to them and I just said, "Hi, Madonna XXX, nice to meet you," and shook both hands. When they went into my office, the guy who looked like "Oh, my God, really?"... said to me, before we started, "You must have been very lucky to get this job." And I said to him, "Actually, it was not luck, I was the best of the many candidates who applied."... And it was in my mind, I'm thinking, how dare you....So you could see his partner, if the ground could have opened and swallowed him, that's what would have happened. And then we ...engaged [in] a discussion and I was very, very professional and again, I figure it's not about me. I still have to be professional, even if afterwards I'm going to talk and dissect what just happened. But in the moment, I don't let myself be frazzled....So anyway, we had the meeting, obviously they didn't get the business and I got a call from the[ir] boss...his partner had...told his boss and the boss*

*apologized profusely. He said “Oh, we’re going to let him go”, and I said, “No don’t let him go. I think what you need to do is you need to be able to give him some opportunities and education.” That is really important, because by letting him go, he’s just going to do that somewhere else. So again, it’s by being able to be assertive, not aggressive, but also examine and reflect at the end of the day, I reflected on-- even right after the situation, whoa, what just happened here?...And how would I deal with that again, if I had to come to it today. (MdI-14)*

Madonna was firm in her belief that emotional reactions based on perceived racism in situations such as this did not enhance the potential for creation of mutual understanding in tense situations. She was consistent in the message “Don’t assume it’s about race, or difference”. She advocated grace under pressure.

*Last week...I ran into a colleague who just got a new job, she’s three months into the job. And she is black and apparently she was supposed to meet with her boss, who is white, and... another colleague, who is also white. She found out they had the meeting without her and she said, that [she] was waiting outside the door, [walking] up and down, up and down, up and down. So she said, “I’m going to go in tomorrow and I’m going to tell them da, da, da, da...And I said, “You know what? I would not approach it that way... No matter what it looks to you, don’t label it before you really examine it.” So I said to her, “I would just go in tomorrow and just say..., I was waiting to be called into the meeting...I was just wondering are we rescheduling it or what happened?”... And hear what the person says, because you also want the person to save [face]...She sent me an email and she said, “Thank you for your advice. I used the approach and then my boss apologized profusely and said actually...they just got totally carried away with something and in that case, then that’s how she missed it and it’s unacceptable...*

*You don't fight fire with fire and I was taught that too from the time I was a little girl. You don't fight fire with fire, you try to work and look at alternatives to be able to get a resolution. (Md1-16)*

This desire to create a win-win, to create linkages and relationships rather than confrontation and blaming was the hallmark of Madonna's approach to issues of diversity.

Addressing the issue of race, Madonna indicated that her commitment to and work in the area of diversity were based in broad issues of justice, not just issues of race. She talked of her commitment to inclusivity.

*...You know what? I have been there and I know when I am excluded, how I feel. You feel marginalized, you feel really disappointed and you just feel very, very...sad. So my goal...is to always equitably include individuals. When I worked at [a disease specific health care organization] ...with HIV and AIDS, the majority of our population...were gay, lesbian, transsexual. And...homosexual, people would say to me, well, why are you working there?...And I said, you know, these are people who need our care and I'm not going to be discriminating about individuals based on lifestyle or sexual preferences or what they do in their life. So that's basically how I see inclusivity, by looking at individuals and also by treating people as I would like to be treated. (md1-9)*

A first glance, one might have interpreted Madonna's "we're all just individuals" position as evidence of her lack of recognition of the structural and political barriers experienced by minorities. Such a position could be viewed as an essentially "color-blind" position, negating culture and ethnicity. This was definitely not Madonna's view. While rejecting treatment based solely on color, she believed that acknowledging and celebrating such difference was important. Madonna was a very proud black woman, and believed that the color of her skin was a very important part of her identity.

Diversity, for Madonna, was viewed in the broadest of senses. Her focus, however, was not on difference; it was on inclusion. She sought inclusion of those who

are different, whether due to race, ethnicity, language, color, gender, sexual orientation or ability. Madonna illustrated the importance of taking a broad view about issues around diversity with the following story. She recalled that when she was doing graduate work, she regularly drove to a distant campus with a colleague.

*Someone...said, "How do you drive with this lady who is so different? She always seems so negative. Everything is about race, everything is about color." But you know what? For her...we went there for four years together, but in the end it was not about race. That, to me, is a success, because she's taken a... totally different spin on many things right now. Which is good because, you know, before the first place she went was usually race related, so therefore all the interactions were negative. But now...it's more than color and we have developed a great friendship one of respect and camaraderie. (Md1-28)*

Madonna's views on diversity were shaped by her personal experiences of being seen as Other. However, she did not let Othering approaches to her keep her from her goals. She was creative and assertive in her approach to barriers in her way. She needed Grade 13 to enter nursing in the province where she first lived when she came to Canada, but only Grade 11 in Quebec. She moved to Quebec. She needed to support herself while upgrading, so she worked nights in a nursing home, and went to school during the day. She needed to pass French in order to be licensed as a nurse in Quebec, but not in another province. She moved to the other province. Her experience of failure in her baccalaureate program could have embittered her, and resulted in a belief that it was all about race. But she was not prepared to accept that, even though she believed that race was a factor. She simply reframed her experience as an opportunity, and moved forward. Madonna simply would not stop until she achieved her goals.

Madonna emphasized the importance of seeing the big picture, of not taking things personally. She was able to reflect on her experiences in a critical way, and in doing so, was able to see her experiences in context, and identify the social and political forces at work. Madonna's ability to look at situations in context created many options



for addressing challenges, rather than simply looking at the issue from the sole perspective of race.

### ***Leadership***

Early influences in Madonna's life led her to her current roles.

**Early influences inspiring Madonna's leadership.** Madonna's successes in leadership within the nursing profession occurred, in her view, due to the influence of her parents. She talked about being raised with the expectation that she would work hard and be successful at whatever she did. This was not the case for all of her immigrant colleagues.

*It's all from my childhood. ...I talk to friends of mine who did not have the support and opportunities that I had and they are not anywhere where I am. ...You know, I think [it's] because of my desire to succeed, because of my knowing that I should always try to achieve something. ...I remember when I moved to Montreal, I started sharing an apartment with a couple of colleagues of mine. And I used to go to night school to complete the grade 11. And...my other two roommates started going to school with me and then they stopped. And they keep telling me, "Why do you keep going? Aren't you tired after work?" .... 'cause I was working as a healthcare aide at a home for the aged.... But you know what? I persevered because I wanted to be there. I wanted to achieve. I wanted to excel...I'm highly motivated to do that. (Md1-8)*

For Madonna, expectation and support inspired the confidence to achieve as a leader.

### ***Critical Leadership***

For Madonna, critical leadership involved being visible, understanding and using power appropriately, and dealing effectively with conflict.

**Leadership is about being visible.** Madonna believed that one of the most important ways of increasing diversity in nursing was to increase the *visibility* of diversity within the profession. Madonna believed that it was important for her, as a black woman,

to be visible within the profession, and to actively promote and represent visibility within the profession.

*...I...talk about my culture...I started telling you where I'm from, in the Caribbean. I always go back to my roots, when I begin with people and in every group that I am at, I talk about diversity...I believe in who I am and I do not negate who I am. ...So by not being afraid to speak my mind...by not being disrespectful to other groups and also by bringing out the issues from a diversity perspective. I do that and I do not use the "r" word as a definition or as a reason. I usually walk through whereas I know I have some colleagues who would just say -- well, I guess they're just racist, so forget it, you know. But I always say let's examine every aspect before we...make a diagnosis.... People see me as one of the faces representing the black population....They see me as at every table. They see that I do not dodge the issues of racism, sexism and all [this] other stuff. But they see that I may agree to disagree with some of the things that they have said, but they also see me as being that persistent woman and sometimes...I am one in a crowd of a thousand people. (Md1-12)*

*I remember one time going to an event and...some went ahead of me and I told them to save a seat for me. And when I came in, they were sitting at the back and they were white women, sitting at the back and I said, "Well, what are you guys doing there?" And they said, "Oh, we saved a seat for you." I said, "No, no, let's go up front." So again, I never try to hide when I'm in a group....But I always try to go out there, I try to mix, I try to be on different boards. I try to represent different issues....I don't make myself invisible anywhere I am. Neither do I make myself an annoyance. I make myself very much involved... and I'm very much a decision maker. (Md1-12)*

One of the most important aspects of Madonna's leadership was her visibility. She embodied the issues she championed, and as such her presence promoted reflection on the issues. She was vibrant and forceful, and did not take a back seat, literally and

metaphorically. Her visibility gave credence to the possibilities for others who have experienced exclusion, and challenged the views of individuals such as the man who visited her in her office who could not accept that she had earned her position of authority and decision-making.

Madonna's message with respect to visibility was: don't hide; be very clear in who you are; be accountable for what you are; don't play the racism card unnecessarily; be upfront and carry the issue in a public way and never remain silent on things that matter.

**Using, not abusing power.** Madonna acknowledged that her visibility around diversity issues gave her power. She was adamant that such power should not be misused, and should not serve personal gain, but be directed to the common good. Madonna understood the importance of power as a leader. She also saw the importance of understanding power as a person of difference in Canadian society. In her work as a health care aide and in watching nurses care for her dying mother, she saw nobility in what they were doing that she thought would give power to her in her status as a woman of color in Canada. This was a job where she could be respected and be successful in the Canadian context. In choosing nursing as a profession, she found a vehicle for her talents as a leader and a change agent. She knew that being in a position to influence society and the profession in the way that she has in nursing, was a privilege.

*It's... using my nursing position or my influence in nursing to be able to achieve and I know I'm not only doing it for me, I'm doing it for the whole of society. (Md1-19)*

*A leader is one who puts others forward and does not take all the credit for him or herself. A leader is one who also realizes that he or she makes mistakes. A leader is also one who should realize, though, that even any formal role that further enhances your leadership [is] really a privileged opportunity and it should not be something that you use to hurt. (Md2-6)*

**Conflict: Having the difficult conversations.** Like the previous leaders, Madonna identified dealing with conflict as a challenge for her. She admitted that she has had to learn some lessons about leadership the hard way.

*But if I had to do it over again, maybe what I would do is raise issues as they came up and not make excuses. You know, like for example, try to have the conversations and ask what's going on---- as opposed to: well, I think this is it. (Md2-26)*

Leadership, for Madonna, entailed being visible, dealing with conflict, understanding power and respecting that power as a privilege, not to be abused.

### ***Transformative Leadership***

For Madonna, passion drove transformation. A vibrant, almost relentless positivity drove her forward. Vitality and enthusiasm were her hallmarks.

**Passionate and vision in leadership.** Passionate and visionary were two words that captured Madonna's approach to leadership for diversity. She had a powerful vision of an inclusive society, and a relentless drive to lead and inspire transformation. She was inexorably motivated to achieve an inclusive society. She moved ever forward, assured of her goals and zealous in her mission.

*...Not everybody has the energy that I have or the enthusiasm....That's my style. (Md2-34)*

### ***Educative Leadership***

Leadership was, for Madonna, an educative process. Leadership involved role modeling, advocacy, and exploring options. However, to be an effective educative leader, it was necessary to be fully engaged with her colleagues.

**Engagement as the first order of educative leadership.** Leaders are engaged and promote engagement in those around them, according to Madonna. She was successful as a leader because she viewed leadership as a relational process, one that demanded engagement of the highest order.

*I became the executive director of this organization about a year ago and one of the strategies the organization had been trying to do is get staff involved and engaged in the foundation.....So one of our service delivery centers decided to do a baseball tournament, and that happened on Saturday. So they sent an email. They said, "Madonna, are you coming?" And I said, "Sure I will." And...the way I responded motivated*

*the group to do the event. The event happened on Saturday, they were able to attract 40 people. They raised quite a bit of money. And then in that case...just to see this whole thing develop because of connecting and because of respecting was really good. And...at about one o'clock one of my colleagues...was just about to leave and she said, "Are you coming, Madonna?" and I said, "Sure"...When I said, "Sure" I looked at the faces of the two organizers and you could see they were very disappointed that I was going to leave halfway through the event, right. So...quickly I said to my colleague, "Go ahead, I will catch up with you later," and I said to the organizers, "I'm with you till the end," and you should have seen their faces. And would you believe, in their email [after the event] the first thing they said is, "It was a great event. We are so happy that Madonna hung on till the end of the event." (Md2-9)*

*So by doing those little things informally or by doing the people thing and recognizing the people then, guess what, then the payout is even greater....It's unintended but it has a very good impact. (Md2-9)*

This story demonstrated a degree of engagement that was important to her, and that she viewed as an important aspect of leadership.

**Leader as mentor.** As a visible black woman in a leadership position that afforded her many opportunities to influence developments, Madonna believed that it was her responsibility to be a mentor to those who sought her out.

*A lot of individuals get in touch with me and say can you do this or can I have your advice. Like, for example, I got an email from someone on Friday, and from the reading the email it told me that that individual wanted to speak with me ASAP... And the individual wanted a discussion with me because she's thinking of making a move from where she is to another [job] ...She brought the posting, she brought the information, she said she's been thinking about it but she also wanted my leadership, my direction, my analysis before she even moved on and put in her*

*resume....It was really a privilege to have someone who wanted you to connect with them based on that. (Md2-7)*

**Leadership means creating possibilities.** Looking for and creating possibilities were hallmarks of Madonna's leadership style. She was always seeking successful solutions and ways of making things better rather than dwelling on why things were bad. This approach explained her reluctance to play the racism card except when it just could not be avoided. She wanted ultimately for diversity to be seen as positive rather than negative. She hoped that diversity would come to be seen as a valuable asset to organizations, and a positive in community life.

Madonna's approach to leadership was one of creating the "win-win". Like Katherine, who admonished leaders not to behave like "brats" in times when they had power, she recognized the importance of leaving for others, places to which they could retreat and reflect, rather than "finishing them off". Her approach to the visitor who treated her in a racist way and her encouragement to his boss to keep him in the position and give him some cross-cultural experiences and education was one of promoting his development, rather than winning at all costs.

For Madonna, using her leadership in an educative way involved engagement, mentoring and creating opportunity.

### ***Ethical Leadership***

Ethical approaches were a must in leadership, according to Madonna. Such approaches were built on honesty, trust and respect.

**Authentic relationships.** She clearly identified the importance of honest, respectful relationships in supporting leadership.

*It's...being able to recognize relationships are important and recognize that you need to be able to respect people. To me that's the basic thing, respect. And these are values that I really hold. And then the value that I'm also not perfect and I don't know what I don't know and if people are there to be able to tell me what I need to do I definitely will. (Md2-16)*

For Madonna, leadership was not positional. It was relational. It was about establishing supportive, effective relationships.

*I would say leadership is about people. ...When I talk to nurse leaders or even professors, put yourself in the students' place especially if it's a diverse group that you're dealing with, because they're going through adjustment issues and then the other issue is trying to learn a system itself. So let us treat everyone with respect, with support... You know, never forget where you come from. Always be humble. It's important that you are humble dealing with people. (Md2-30)*

Madonna identified the importance of having support as a leader. She acknowledged the support she received in an ongoing way from a former colleague and program director.

*But the way she respected and included, and she continued being available to give me support, direction, even throughout my term at the university, even throughout my term at the professional association, and even now she calls and says how are you doing, how are things going. So knowing that that individual is available and I can always reach out to her, to me that's leadership. It's not what they get out of it, it's...how they respond to you. So it's being able to take that giant leap. It's people who have the faith, and that's what I see as leadership. (Md2-11)*

Successful leadership, for Madonna, balanced a healthy confidence in her abilities, with humility. "Never forget where you came from" she admonished.

Consistent with an ethical leadership style was Madonna's desire to create win-wins, and to allow others to "save face" in situations of disagreement. Madonna espoused a commitment to ethical leadership, whereby power is used to help, not to hurt.

### ***Inclusive Leadership***

Madonna identified the importance of involving all participants as part of providing leadership.

*...I strongly believe in that little thing they say, "Leadership at all levels." ...It's not about the title or the position, it's about how do you work with individuals to demonstrate what [leadership] means and also relinquishing the role. It's true that we do have a role*

*because...organizationally it's a formal role, but it's usually the informal leaders most of the time that make the difference and have the greatest impact. (Md2-6)*

The importance of “leadership at all levels” showed Madonna’s commitment to inclusive approaches to diversity that involved others and advanced their understanding of the issues. Her approach was one of boundless optimism and a positive belief in people despite her negative experiences.

### ***Professional Closure***

Madonna did not directly address the issue of professional closure in her discussion of diversity and leadership. However, her story of the importance of becoming a registered nurse as a way for a woman of color to gain acceptance and status in Canadian society illustrated the importance of achieving professional status as a mechanism for inclusion in Canadian society. Her description of the challenges she experienced in gaining entrance to an education program, successfully completing her education, and becoming registered despite language requirements illustrated aspects of professional closure practiced by the nursing profession.

### ***Madonna’s Story: Conclusion***

Madonna’s interest in and approach to diversity came from being different in the Canadian context. Being different informed her approach and played a significant part in who she was. She was from another country, spoke with an accent, had a different skin color, and those were important aspects of who she was. But it was not being different that moved her forward; it was inclusion that moved her. Finding and building strategies for inclusion were the major foci of her leadership. Her approach to leadership for inclusion was summed up in the following comment.

*I’m going across the province to talk about cultural competence and to talk about how we reach people; how do we work with individuals and make them feel included.... I think it’s everyone’s responsibility but I think we really should realize, though [that, in the end,] we’re all people. It’s about people. It’s about human beings. And that’s what, to me, drives me, is that piece. Because... it’s about being us. (Md2-2)*



It was as an authentic leader, committed to establishing positive relationships, functioning in an ethical manner, modeling inclusive leadership, and acting with a relentless optimism in the ability to affect change that Madonna exercised leadership to increase diversity in the nursing profession.

### **Mariam's Story: Infected with Passion or "Persuasive, not Abrasive"**

Mariam was an immigrant from a predominantly Muslim country in the Middle East. She came to Canada in the late 1980's as a single parent with a three-year-old son, to escape civil war in her home country. Unlike the previous participants, she completed her undergraduate nursing degree internationally, in her home country, adding a master's degree in nursing after her arrival in Canada. She occupied roles of increasing administrative and leadership responsibility throughout her career, including coordination of nursing education in a major urban hospital, and a consultancy at a national nursing organization. Her position at the time of the interview was one of leadership at a large urban hospital in central Canada. Part of her portfolio included education and consultation on issues of diversity, inclusion and cultural competence within the hospital, as well as in the community. Mariam described herself as a dark-skinned member of a visible minority. Although she originated from a predominantly Muslim country, Mariam was a Christian, and her faith played a significant role in her approach to leadership and diversity.

### ***Diversity and Inclusion***

Describing how she came to be a nurse, Mariam talked of how personal experiences with nurses positively impacted her life.

*I think I was born a nurse....As far as I can remember...I wanted to be a nurse....Because I was a sickly child and I really valued the nurses who took care of me as I was growing up and I just wanted to be a nurse.*

*I grew up with tonsillitis....I would have three or four bouts of tonsillitis every winter...and I was very sick with it....So I dealt with the healthcare system from a very, very young age. (Mm1-2)*

*...I received regular injections, IM [intramuscular] injections of Penicillin....As a child receiving that was one of the worst experiences.*

*But the nurses were just so gentle with me and understood what I was going through....To them I was a brave child...they were caring....Even at the tender age of six and seven they would tell me what they were going to do and yes, it's going to hurt a little bit and here's what I can do afterwards to make it better. And would talk to my mom and support my mom through it as well. ...There were times when I could barely breathe and they seemed to understand all that in a way that my mom couldn't when she was caring for so many other children, you know. The nurses were much more open to my experience and to helping me through it, so they became my heroes. (Mm1-3)*

For Mariam, nursing was an avenue to affect powerful change in people's lives. This was very attractive to her. However, she explained that her family was not supportive of her career choice.

*...In my country nursing is not valued as an honorable profession. It is considered more of a glorified maid kind of thing...When I was growing up I grew up upper middle class...so it was really not quite acceptable to my family that I was going into nursing but I did anyway. (Mm1-2)*

Mariam described how she came to live and nurse in Canada.

*I got my nursing in my home country and I worked in the capital...but then ended up at the XXX hospital during the civil war...I got married in my home country and I had a child.... And then my husband disappeared in the war and I made a decision that if I wanted to have a future for my son I needed to exit....So I came to Canada...as a single mom with a three year old. (Mm1-4)*

Getting registered as a nurse when she first came to Canada was challenging for Mariam.

*The provincial regulatory body was very good in getting my application through and allowing me to sit for the exam, so within six months I was sitting for the CRNE [the national RN registration exam].(Mm1-4)*

Mariam felt well supported in the registration process. While she was positive about the support she received, the process was not without difficulties.

*I came in....June....Within a few days I contacted the [regulatory body] because I knew I needed a license to be able to work....There was no email at the time, so it was all by phone or letter.*

*The person who was actually helping me was very open-- you know, opened my file immediately, sent me all the forms that I needed. The only delay was because sending forms at the time to my home country and getting responses, there was no postal service. So I actually had to wait for people who were going to my home country, send the forms over to my parents who would then drive them to the university, have them filled and then wait for someone coming back to Canada to send them....You know, you look back and think this is so comical, but that's what happened.*

*(Mm1-6)*

Her determination to get registered so that she could work in her chosen profession and support her son did not stop when the forms arrived from her home country.

*And when they saw my credentials....they had asked for me to do the TOEFL, the Test of English as a Foreign Language-- but I couldn't afford the fees so I said, no, I'm not going to sit for that because I've studied in English all my life, I speak English much better than I speak Arabic. All my studying was in English and my practice is in English. I worked at an English-speaking university...And so I said, no, I will not sit for the TOEFL. So they said could you please come to XXX [a major city several hours travel from where Mariam was living] and appear in front of the panel to just defend your... position, and so I did.*

*I was so nervous because they walked me into this room and there were literally around 30 people in a circle around the room-- and they slapped me in the middle...or at least that's my recollection of the experience because my knees were knocking so hard. But...they were very respectful*

*in the way they approached me. They realized right away that yes, ...I'm quite comfortable communicating in English and that it is actually my working language. And ...even after the deadline they allowed me to ...sit for the [CRNE] exam in January. So I appeared in front of the panel in December, I sat for the exam in January, and I was working in February. You know I was able to speed through the process. It was really very gratifying. (Mm1-7)*

It is a testament to Mariam's fortitude that she described this process as supportive and helpful. Many others would have felt overwhelmed by such processes. Her experience as a person of difference continued during her employment in Canada.

*My first position in nursing in this city...I remember the manager telling me you're overqualified for this position and I can't trust that you will be in this position a year from now so I can't offer you a job. She gave me one reluctantly....because I sort of negotiated myself into that position.... I only left that position, actually, when I was laid off because I was too junior. In the early 1990's there were massive layoffs--and I was one of those people who was too junior. So, interestingly, you know, being overqualified did not factor in. (Mm1-5)*

With some resentment, Mariam spoke of the assumptions made about her by the manager.

*...Her reaction that "Oh, you're overqualified. I'm not going to give you the job" was to me like, well, you want good people....Why would you say that I'm going to let you down when you haven't even given me a chance? And to me every time...they expected less of me... I was challenged to do more. (Mm1-8)*

This statement of determination summarized Mariam's approach to nursing and life in Canada. She frequently experienced prejudice and found herself faced with road blocks, but she refused to accept defeat. She was constantly "challenged to do more".

Mariam talked about how the skills of immigrants and other people of difference are often discounted.

*One of the questions that I was asked when I first came to Canada, in that first interview, was about...Canadian experience....Where have you worked in Canada and are you familiar with the Canadian healthcare system and that is a very valid question. But also in the same breath, five years of experience in a war-torn zone where every skill within the scope of practice was utilized to the maximum was simply dismissed. So to me, all they saw was, oh well, you've got experience in a foreign country, full stop. It's not the fact that that experience might in so many ways surpass the experience of someone else who has worked in Canada but in a very limited context. And so that is one thing that always irked me because I felt all the time that I was working twice as hard to be recognized only as much as everybody else. (MmI-21)*

She was called on to use this determination to succeed when she became interested in advancing her education, but experienced barriers in receiving credit for her nursing degree, which she had completed in her home country.

*And I got so interested in graduate studies and I applied to XXX to the Masters program but was denied because of my foreign credentials. So...I did two courses as a special student, got A-pluses on them and reapplied.... So I thought, okay, I'll get in the back door, you know. Actually, the two courses that I took were the stats courses, the statistics, which were considered the hardest courses in the whole program.... So I was confident enough to go back and say, okay...here are the two most difficult courses in the program and I got A-pluses, you've got to let me in, and they let me in the next year but I just felt so silly having to do that. (MmI-10)*

Not one to take no for an answer, Mariam challenged the barriers put in her way. The barriers continued to appear, but her indomitable "I'll just make it happen" attitude prevailed.

*Around that time I applied for an educator position here at this hospital and went and became the educator for CCU [Coronary Care Unit] and*

*cardiology. And I remember that director afterwards telling me that...she felt I was British because of my accent and she said that had she known [I] was from the Middle East she might have hesitated to offer me the job. (Mm1-5)*

Mariam described more of her experiences with prejudice and discrimination in practice in those early years.

*The Gulf War happened in 1991. And it was very interesting to see the reaction of the staff around me....They knew I was from the Middle East but I think part of it is that an Arab is an Arab to people who don't know us, and so I would walk into a room and silence would take place. Like, people would stop talking.*

*They didn't want to go to break with me, so I would go to lunch and coffee alone. Things like that that were just like, oh, my word, like what's happening here? And then again,...with the 9/11 and things like that you see that people's reaction, the fear is so obvious when people don't understand where you're coming from when they look at you and see skin color or accent or cultural heritage rather than you as a person. (Mm1-9)*

The dismissive treatment she received as a woman of color in her early years in Canada was vividly illustrated in the following story:

*About ten years ago now, my mom...had a cardiopulmonary arrest at home...I had finished a 12-hour shift...at one o'clock in the morning my dad comes rushing into my room, "Just come see. I don't know what's wrong with your mom." And I walk into their room and she's blue, no pulse, no respiration, so I start CPR [Cardio Pulmonary Resuscitation]. I was, thankfully, a critical care nurse and...I had just done the ACLS [Advanced Cardiac Life Support], right, so I had all the things in my head...but at the same time I'm shouting things at my brother who was talking to the 911 operator....By the time the paramedics got there my mom was already breathing. She had a faint pulse. She was still unconscious but she was breathing on her own and I had her in the*

*resuscitation position but she was completely out of it.... The paramedics walked in...so here I am blurbing to them here's her pulse, here's her respiration, this is what I've done, and they're simply...ignoring me. (Mm1-21)*

Mariam, upset, described how all of the information given by her to the paramedics was completely ignored, and never made it on to her mother's chart. Her mother was taken to hospital and treated there, but no one there knew that she had, in fact, had a cardiac arrest at home, because the paramedics dismissed the very significant information Mariam had supplied to them.

*It actually never made it onto the paramedic record that she had a cardiopulmonary arrest. She had permanent changes on her ECG, that she still has, and some neurological deficits, that she still has, and they wanted to dismiss us home six hours later and to me it was like completely overlooking anything I reported to them. Because the first thing they saw was this dark-skinned, heavy-accented person who was-- I was speaking probably to them in tongues because I was communicating with my dad who was frantic, so here I am speaking to him in Arabic, speaking to them in English and probably mixing them up in between and it was one o'clock in the morning ...I felt at the time that all my career, all the credibility that I had built over years was just completely overlooked. (Mm1-22)*

Mariam's description of how her expertise was dismissed echoed John's view that those who are different are often dismissed or viewed as stupid, whether they are immigrants, youth or others considered to be on the margins.

These stories revealed a past that was fraught with experiences of prejudice and racism. Mariam's experiences of exclusion included being told that she would not have been hired if the person doing the hiring had known that she was from the Middle East, rather than Britain; not being allowed to register in university based on her foreign credentials; being shunned at work at the time of the Gulf War and 9-11; having her knowledge dismissed when reporting her findings to the paramedics transporting her mother to the hospital; and having her nursing expertise dismissed as irrelevant to the

Canadian setting, despite her advanced practice in a war setting. All of these experiences were based on other's preconceptions of her, rather than the reality of her situation. These preconceptions were based on her skin color, her accent, her ethnicity and her immigration status.

Despite her claims that her attempts to register as a nurse in Canada were well supported and without difficulty, she painted a different picture with her description of the panel of thirty people who listened to her defense regarding their request that she prove her English language proficiency. Some might have viewed this as less than supportive, and bureaucratic. Some might also have seen as bureaucratic and unnecessarily obstructionist the graduate school admission process that necessitated taking courses to prove herself prior to admission. While she saw these processes as generally supportive, the processes around professional registration and acceptance to graduate school were challenging, expensive and time-consuming. Perhaps it was her quiet optimism, steely determination and positive attitude that filtered this process, making it seem supportive and relatively barrier-free, where others would have seen significant obstacles. Perhaps also her experiences with corruption in her homeland made these experiences appear positive because they did not require bribes or involve fear, manipulation and intimidation. Mariam's description of how she was ostracized at the time of the Gulf War and 9-11, based on her colleagues' fear of her perceived "Arabness" illustrated the fear of difference that was first seen in John's discussion of his parents' reaction to difference.

From Mariam's perspective, attempting to deal with issues of difference in Canadian society usually engendered conflict. She talked about what frequently happened during the workshops on diversity and inclusion offered to staff in the institution where she worked.

*Well, I can tell you about some of the workshops we've done. I've had, ...one person stand up in the room and say, "Why do I have to learn about their culture? They come here they need to learn about my culture." So these are some of the things that you deal with when you're trying to impress on someone that...I'm challenging the way you're*



*practicing. It is not meeting the needs of your patients and you need to look at your practice and find ways in which you can meet the needs of your patients and this person just did not want to see it. You always get, in any kind of workshop that you run, yes, you get those who are right there with you, understand completely and just want you to give them strategies: show me how to do it and I'm going to go out there and do it. And you've got those who just want to stand on this side of the fence, don't want to even look over at the fence, and you are not going to change their position, who are truly ethnocentric and who truly do not want to move. And partly-- I've discovered that [much] of that is because of personal experiences that just will not allow them to move beyond. But these are things that happened in practically every single workshop. People don't sit on the fence on this. (Mm1-29)*

Not all experiences of diversity and exclusion related to culture, ethnicity or race, in Mariam's eye. She viewed diversity as the uniqueness of individuals.

*You see I'm a visible minority here. I was born a woman in an Arab country. I was a single mom and a nurse in a society that values neither. I was a Christian in a predominantly Muslim part of the world. Very early in my career I had to advocate for a 13-year-old brother with cancer...All of those stories are part of [diversity] ... I'm sure you have stories of your own that you can share about how we are different and because we're different each one of us will have a story to tell about that. (Mm1-24)*

*So if there is a value that I see in there... I have to look beyond the surface. You know the theorist or the researcher...who said... we're like an iceberg.... 7/8th of us is really beneath the surface and if I'm going to treat someone... and think that I can make a decision about their future or about their health or about their wellbeing based on only the 1/8th that I see, which is their skin color or their accent or their hair color, well, I'm grossly mistaken. And so yes, we need to just look beyond the surface. We need to look at the person and see the value of the person regardless of*

*their accents, regardless of their color, regardless of their cultural heritage. We have to see the inherent value of a person as a person and as someone who is created equal to us. (Mm1-17)*

Mariam was convinced that the solutions to the issues surrounding inclusiveness were apparent, but there was a lack of commitment to implementing them. She described a situation that arose when she was consulted by an agency in the community about diversity issues in their organization.

*...When I was consulted...to look at the hiring practices of an agency here in town who found themselves hiring mostly African immigrants into some of the frontline caregiver positions and were having major clashes between the frontline workers and the management....I went in and I did the usual assessment, I looked at their postings, their hiring practices, their interviewing processes and then I looked at their management structure. And it was so obvious that you've got a management that's all white and you've got a frontline workforce that is mostly non-white and so you've got cultural values and communication issues that were just so completely outstanding.*

*...And, of course...my recommendations always include you know what, you're going to get two candidates, equal qualifications, one is going to be black, one is going to be white. You know, put it bluntly on the table... I'm going to recommend you hire the black into management positions and they always balk at that. Well, they won't fit in. You know, we won't know how to treat them. We wouldn't know what to do if they were part of this team....And many of them are not willing to take the extra step to change the foundation...the processes, in order to be more inclusive because it's much more work.(Mm1-23)*

Organizations that continued to see diversity as being about the Other were not equipped to make the changes necessary to embrace inclusion, in Mariam's view.

The nursing profession, from Mariam's perspective, was not truly committed to inclusion. She believed that, while the profession was to be commended for its

development of policy positions and best practice guidelines, it did not operationalize these policy initiatives, even in the narrowest of senses. This was largely due to the prevailing view that diversity was about “them”. White was seen as the neutral culture, with anything else being Other.

*We have had recommendations and research and reports and language changes and guidelines and standards and position statements forever. But the problem is... if you look at all of these, it keeps on boiling down to ethnicity and race. Yes, in the last few years, we've added the language around sexual orientation, we've added the language around abilities or, you know, differing abilities. We've started adding some of the language around religion, etc. But it's still others versus us and part of it is because we still believe that the white Anglo Saxon culture is us and everybody else is others. And the fact that most of our nursing leadership is white Anglo Saxon us, we will still view others as the diversity and not us.... But until we start seeing ourselves as part of that diversity, it's still going to be somebody else's problem.... One of my major disappointments is that we worked for two years, three years on a set of provincial best practice guidelines on diversity. We have major recommendations for organizations, for government, for schools, none of which have been enacted, none. Why? When you've got something that is research-based, evidence-based and that will influence your outcomes, why have people just left it on the shelf? It's because it's uncomfortable. We need to stop thinking, oh, this is uncomfortable, because you know what? We're going to reach a stage where we don't have enough nurses and who are you going to promote into that position of leader, when you do not have-- and I'm sorry, I'm going to say this-- when you do not have a white Anglo Saxon candidate? You know? We just have to stop being so ethnocentric. And we are, we're still ethnocentric in our nursing, despite the fact that our beliefs and our tenets oppose it, but we still are. (Mm2-22)*

*...Look at our ranks. Look at who leads us academically, management in a clinical setting, policy, research, you know, we still exclude diversity. We still exclude cultural minorities out of our research...So as a profession we speak very well but we haven't built it in. And every time you speak about positive action, oh...you're just raising red flags everywhere. So, yeah, we need to do much more as a profession. (Mm1-32)*

*...I truly believe that many of our nursing leaders who should lead those actions just don't view themselves as part of the diversity and so until they do why would they bother? You know, it's simply not in their horizon....And until we stop this cappuccino effect, you know the white on top and dark in the bottom, I don't think we're going to move fast. It's just not real to them, and perhaps they don't know what to do. Perhaps they need to...move forward with...recruiting out of the ranks to help them put those strategies in place but we haven't reached that stage. (M1-32)*

Mariam was adamant that, until nursing leaders viewed difference as involving and including them, rather than being about someone else, the profession would not move forward. She challenged those leaders to see themselves as part of the diversity within the profession.

*[Nursing leaders need to see] that they are part of the diversity. That it starts with them, moving beyond their own comfort zone and the status quo that they've been comfortable with. That [what they have done until now] has proved ineffective and that they need to address that...Diversity is not defined by ethnicity and race, but by the uniqueness of each individual and that they need to be the change. I know it's corny, but you know what, they do. They need to be the change, it starts with them. (Mm2-21)*

Diversity was much broader than ethnicity, culture or race, in Mariam's view. She believed that we are all part of diversity, and should not be essentialized through attribution of characteristics, based on skin color, accent or immigration status.

In her view, the approach that difference is about “someone else” was a major obstacle to resolving issues around diversity. Seeing difference as being about someone else removed the impetus from the white leadership in the profession to take any action. It problematized difference, and let the leadership of the profession off the hook, because it was about someone else, not them.

Mariam was critical of the profession for its lack of action to address diversity issues. She criticized the profession for its lack of willingness to address diversity. She attributed this lack of willingness to the discomfort the profession felt when confronted with the conflicts that arose in creating a diverse profession. Her message was clear: Deal with it. She challenged the profession to look past programs directed at changing behavior, to focus on dialogue intended to change thinking.

Her Christian faith strongly influenced Mariam’s view of diversity. She believed that all humans are created in the image of God, and as such are equal in the eyes of God. Her commitment to addressing issues of diversity in the profession was based on a view of social justice driven by her Christian beliefs. Her Christian beliefs also played a large role in her approach to leadership, as we shall see in the following discussion.

### ***Leadership***

Like the other participants, Mariam viewed her leadership tendencies as originating in her early life.

**Early influences on leadership.** Mariam attributed her approaches to leadership and diversity to her parents and their approaches in raising her.

*...Some of those values and beliefs were definitely instilled in me by my parents through my own personal relationship with them. The way they’ve conducted their lives has definitely sparked a lot of where I am today.*

*(Mm1-35)*

Traces of Mariam’s leadership qualities were seen in her discussion of her childhood dream to be a nurse. Despite her family’s opposition, she did it anyway. This summed up the tenacity with which Mariam approached all of the challenges in her career. When confronted with a challenge, she met it head on (appeared before the panel

to state her case regarding her English language proficiency; found a better job after layoff) or simply found a way around the issue (enrolled in the two most difficult courses and getting A pluses, thereby forcing admission to the graduate program). This quiet determination was the hallmark of her professional experience in Canada, and impacted her approach to leadership.

### ***Critical Leadership***

For Mariam, leadership involved reflecting on and critiquing power relationships. From Mariam's perspective, leaders required an understanding of power and power relationships in order to be successful in their leadership.

**Understanding power as a leader.** Mariam spoke of her view of power, and how power was to be used effectively. Her views were shaped by her history of living in a country at war. To her, power was about positive influence.

*You know what? My life experience...includes living through a civil war that ...was mainly due to corruption in leadership. So to me, when I look at a leader, I don't see power or hunger for power. It's not about political or physical power...Because of all that experience with civil war and social injustice, to me, I feel that leadership is about influence, but positive influence and...when you lead, you have to consider others before yourself. And so to me, that's leadership and probably my view of leadership has been greatly influenced by my life experience in a civil war. (Mm2-16)*

Power, for Mariam, had negative connotations, given her experience of fleeing a country torn by war, a war that occurred as a result of leadership corruption. Her view of power was summed up as "power to serve". Power was to be used to serve others.

### ***Transformative Leadership***

Passion and vision were important aspects of Mariam's leadership. Her passionate critique of existing practices was balanced by an equally passionate vision of what could be.

**Leadership is about sharing passion.** Like the other participants in this study, Mariam was passionate about inclusion in the profession. She constantly referred to her

“soapbox” and to “shouting from the rooftops”. Mariam viewed a passionate commitment to inclusion as an essential part of nursing. She clearly and vigorously articulated this passion.

*One of the things that I’ve always hated and I know “hate” is a strong word but I use it...intentionally, I’ve always hated injustice, and to me there is absolutely no room for it and no reason for it, whatever the circumstance or the context. (Mm1-16)*

Injustice was a strong impetus for action in Mariam’s world.

*So when I look at my own experiences and all those of my patients and my family I see those things, I see...it’s because someone had a...perception that they suffered. You know, it’s because someone came with a different expectation that I had to suffer or my patient had to suffer, and these are perceptions or pre-conceptions...that are unfounded and to me that pushes me forward....To me, when I see something that needs to be fixed I have to do something about it or I can’t live with myself. I shout it from the rooftop. Because I nag people and challenge people and challenge myself, you know. I’ve been doing this for years. I’ve never missed an opportunity to just...stand on a soapbox and preach. (Mm1-30)*

Mariam viewed leadership as sharing passion with your followers.

*People don’t follow blindly....People need to be given something to be passionate about. They need to be infected by your passion or they won’t follow. They have to own it as well. So it’s not just your passion and they’re following you blindly, it becomes their battle. Give them a reason to be passionate as well. (Mm2-10)*

**Leadership vision based on beliefs.** Infecting others with your passion occurs when you shared your vision as a leader. Mariam talked about XXX, a highly respected and effective national nurse leader, with whom she has worked closely.

*She is completely driven. She has a vision that she is able to translate to us as her team and to others. Her ability to influence people is astounding as well. She is willing to involve us as her team in both the visioning and*

*the planning, but she also goes to the mat for us. She sees potential in people and she cultivates it....She pushes the limits on our abilities, but she also knows when to stop...She respects, I think, the autonomy that we have, but she also insists on accountability and her passion for nursing is just very, very infectious. (Mm2-11)*

*She has an unwavering belief in nursing. She just loves nursing. Her passion is amazing and you know what? ... It is consistent....She is someone who will still go and do buddy shifts on the units, so that she can have an insider's view of what the nurses are living...She is so driven and so passionate about the value of nursing and again, she sees her role in moving it forward and she takes it seriously. It's not somebody else's battle, it's her battle. (Mm2-14)*

*...She is just amazing; I just respect her so much. Another person that I've worked with....I found that person much more involved in their own vision, in their own goals, rather than the goals of the organization and the profession. And to me, when you turn inwards, you...lose the loyalty of your team. And so...you need to be able to let go of your own goals, or see how the goals of the profession and the goals of the organization can match yours. Because yes, we have our own personal goals, but they should not come first. (Mm2-12)*

Her Christian faith anchored Mariam's commitment to transformation and social justice. Leadership pushed forward the social justice agenda that was embedded in her Christian faith.

*I'm a Christian and I truly believe that we are all created in the image of God and that we are all equal and that until forfeited we truly deserve equal opportunity. (Mm1-34)*

*To me, the ultimate leader is Christ. He is humble, but a true servant and his passion for his cause cost him his life, right? So it's completely unparalleled. But the thing that he also did, that is not as well considered, is that he left them equipped. Not only did he model the passion...of his*



*purpose in life, he also prepared his followers, with all that they need to continue that vision after he was gone. And I feel that that is the ultimate leader. (Mm2-11)*

Her faith guided her view of leadership. She provided a clear message to leaders, based on her beliefs.

*My message would be, leadership starts with servanthood. Whom are they serving and how are they doing this? That insight, they have to have that. It's not about personal power. It's about knowing...how are they going to sustain that change and how are they going to equip the people around them to get there and stay there? I think ...they need to know that it starts with them. They have to model it. (Mm2-20)*

*...I actually believe that as a leader, you do have an obligation to advocate for your patients and as a leader, you also need to smooth the way for your team. ...Currently my team consists of eight people who work with me on the projects I'm working with. And I see my role as supporting what they do, not necessarily them doing my bidding. I smooth the way for them, I make sure that they know where the vision is, where they're supposed to be going and then I make sure that they're equipped to get there. What are the hurdles within the road to us getting to that direction and what I can do, as the leader, in smoothing those hurdles I support them as they move forward...I do realize that the same way people model their leadership around people they admire, I model my leadership around my Christ. (Mm2-4)*

*But as well, what they can do in smoothing the hurdles for one another....I felt as if my role was really meshing all the team members together, but at the same time, keeping them focused in the same direction....I take care of the peripheries for them... so that they can do the work they do. They're not doing my bidding; I'm rather serving them. (Mm2-8)*

Mariam saw her role as a servant leader, supporting her colleagues to accomplish the vision of the organization. It was her job to “manage the peripheries”—to address the

issues which would limit accomplishing the task at hand, and allow her colleagues to succeed in achieving their goals.

### ***Educative Leadership***

Leadership was educative for Mariam in that it was about creating and sustaining opportunities, and being strategic. Leaders recognized the need for creating understanding, and possessed the skills to stick handle the implementation of solutions.

**Creating and sustaining opportunities.** Like the previous participants in this study, Mariam sought out and created opportunities as a leader. Mariam developed a diversity orientation program for the major hospital where she worked, and negotiated the support of a significant leader within the organization to champion this program.

*At that time it started with a very simple half-hour session in nursing orientation, she said if you can do it, go do it, and I did....So every nurse that came to the hospital was introduced to that. And then it became one hour and out of that one hour we developed full-day workshops and then full-week workshops. And then we had a corporate advisory committee to the senior management around cultural issues, because we started also hearing from our own communities that we were serving that many of our personnel were not respecting their diversity and so I was asked also to be part of that, and then we started going...city-wide and region-wide....But it all started with, okay, there's something wrong and it needs to be fixed and I know how to do this, so just give me a chance to fix it kind of thing. (Mm1-26)*

She talked of the importance not only of creating opportunities, but of sustaining them.

*...One of [my] successes...was the inclusion of the...of cultural competence sessions as part of nursing orientation here at this hospital. I was able to influence the creation of a corporate committee as an advisory to the board on cultural diversity. The thing is, when I left here to go work [somewhere else] for two years, these fell by the wayside. When I came back, to my dismay, the corporate committee had been dismantled and the*

*orientation no longer had cultural competence as a session. ...I think what caused the less-than-optimal result or sustainability, is the fact that, even though I influenced one leader, I didn't influence all the leaders. Because that leader had left as well and so when that leader left and I left, what we had failed to do is [create] sustainable change. We changed some behaviors, but...we were not completely successful in changing the way of thinking. (Mm2-18)*

**The importance of being strategic.** Reflecting on the eventual demise of the cultural competence orientation sessions, and the lack of sustainability of the idea, Mariam spoke of the intoxicating enthusiasm of a new idea, and how things could often go wrong unless careful thought and planning is employed.

*Well, you know...when you're doing [something] for the first time, I was guided more by my passion and I wanted something to happen and happen as soon as possible. I should have been a bit more strategic. (Mm2-19)*

Now, as an experienced leader in the area she viewed her role quite differently from that of simply an initiating enthusiast.

*And so I see my role more of a persuader and influencer and yes, it might be influencing the CEO or the VP or the director at some level. But I also see... supporting them in translating that vision as well into concrete items... (Mm2-9)*

*Well, one of the things that you start realizing very fast when you're dealing with senior management is that...you can influence them...in different ways. When you're talking to the CFO, the bottom line is the dollar. So you want to bring back a financial outcome to them. When you're talking to the VP of professional practice and...the chief nurse, you want to bring it back to influence outcomes related to patient safety, but also outcomes related to professional scope of practice. When you're speaking to the CEO, the issue is also the influence on the community...It's like a chess game. [laughs] (Mm2-19)*

Mariam made an important point with respect to sustaining opportunities. She admitted that at times in the past she let her passion rule her head, and moved forward on initiatives before she had strategically built support. As a result, her initiatives failed for lack of foundation. Strategy ultimately became an important aspect of her leadership approach. She talked of the importance of tailoring one's message to one's listener, and knowing what motivated them. The Chief Executive Officer was interested in public engagement, the Chief Financial Officer, in the bottom line. She learned that, when pitching ideas, one needed to consider carefully what was "in it" for the listener.

In her discussion of leadership and strategy as a chess game, Mariam painted a revealing picture of her view of the educative aspects of leadership. She talked about the importance of educating all leaders, not just one, and of the strategic approaches necessary when attempting to move forward the diversity agenda within an organization.

Her description of failed leadership, where her "passion ruled her head" and she got out too far in front of her colleagues was a cautionary tale for all leaders. The importance of "infecting" her colleagues with her passion addressed the importance of leaders being educative and strategic in attempting to accomplish their goals.

### ***Ethical Leadership***

Mariam's approach to people was based on a belief that people were inherently good, created in God's image.

**Advocacy.** Nurses, as professionals, have an ethical obligation to advocate for diverse clients within the system, in Mariam's view.

*And I think one of the things that I see whether it's in my own experiences or in the experiences of my family when they immigrated...or in the experiences of my patients, you know, as they've tried to navigate through a healthcare system, I feel that...we have an obligation as a profession and as nurses to protect them and advocate for them. (Mm1-17)*

Mariam's career was dedicated to advocacy from a social justice perspective, a social justice perspective based, as we have seen, in her Christian beliefs.

### ***Inclusive Leadership***

Leadership, for Mariam, was all about inclusion.

*Well, that is my soapbox, right? This is what I do. I try to communicate to people about the need to view them[selves] as part of diversity, right?*

*Like, the same way I'm different they're different. Because the same way they're looking at me and seeing a dark-skinned Canadian person I'm looking at them seeing a white Anglo-Saxon person, you know. So they're part of the diversity as much as I am part of the diversity. (Mm1-18)*

*To me diversity is a state of being, right.... Every single one of us has their own culture and is different...and we self-define that culture....If you ask me to define myself, my first label is not the fact that I'm...dark-skinned Canadian...Every single person is unique. I do not represent Middle Eastern Canadians. I do not represent all nurses. I do not represent all married women who work in project management. I only represent myself. And because of that I expect to be treated individually and that's why I treat all other people who come into my life individually. I don't look at them and see a skin color and say, oh, there's a Haitian person who will react this way. No, I will treat them as a person who I have to assess for their reaction. So to me, diversity is a state of being and it's very individual and it's very dynamic. Because when I came to Canada in 1989, the person who came is very different from the person I am today in 2009. I have gained life experience that is different, that has changed me forever, and I expect the same thing of everybody around me; that their life experience will change them. So yes, we are part of the diversity, everyone is different, and we all carry our own baggage....Inclusion on the other hand is a value that we all need to work towards because you see as long as we do not see ourselves as part of that diversity why would we possibly work to include others, right? (Mm1-19)*

Mariam's goal was one of an inclusive society valuing individuals, who were all created in God's image. The process she espoused was one of service to others in facilitating them to achieve their goals.

### ***Mariam's Story: Conclusion***

Mariam's approach to leadership for diversity within the nursing profession can be summed up in her previously noted statement "To me, when I see something that needs to be fixed I have to do something about it or I can't live with myself". Of the role of the profession in creating a more inclusive society she said

*...It comes back to seeing others as the diversity [rather than] ourselves. We don't see ourselves as part of that diversity. And so you know what, let others deal with it. But we can't keep on passing the buck, we can't. We can't afford it anymore. (Mm2-22)*

Driven by a strong faith which was lived and expressed daily Mariam, through her intolerance of complacency and her desire to make things uncomfortable strove to create a discomfort strong enough to force the profession to address issues of inclusion.

### **Five Stories: Meta-analysis of Emerging Themes**

#### ***Introduction***

This section of the chapter compares the stories of the participants with respect to the study's conceptual themes: diversity, leadership, professional closure, and relevant subthemes.

The study participants were chosen to participate through purposive sampling techniques. The final group of participants emerged from my contacts with national nursing leaders, who identified the first round participants, (Mark, John and Madonna), and from the first round participants themselves, who identified Katherine and Mariam. I made modest attempts to ensure a mix of experiences in relation to Aboriginal, visible minority and immigrant peoples. However, distribution relating to other characteristics was serendipitous: gender mix (two males, three females), location (three in central Canada, two in western Canada), and ethnic mix (three Caucasian, two immigrants, one of whom completed nursing education internationally, and one who completed her nursing education in Canada). The sampling techniques identified a remarkable and diverse group of leaders. Their eloquence and passion were evident from the start of the first interview. They engaged completely in the interviews, and shared candidly their experiences and their views.

### ***Diversity and Inclusion***

This section of the chapter compares the stories of the participants with respect to their views on and experiences with diversity and inclusion. Comparisons occur in relation to the subthemes that arose from the stories, which are included here as titles for each of the subsections of analysis.

#### ***Difference: Not Just About Color***

Most of these leaders adopted broad perspectives and approaches to difference. For most of them, their interest in difference and inclusion did not relate simply to ethnicity and culture. It related also to sexual orientation, ability, and gender. John expressed the view that nursing rejected not just physical difference and personal characteristics, but diversity of thinking. John, Mark and Mariam all described a profession that was not open to the consideration of difference at a variety of levels.

#### ***Impact of Personal Experiences of Difference: Being Other***

Most of the study participants personally experienced difference. These experiences impacted their personal and professional approaches to inclusion and difference. Mark's experience of a mother with mental illness and an alcoholic father set him apart from his friends. He also went on to experience exclusion based on difference - his gender -- in his undergraduate nursing program, as did John. Madonna and Mariam both experienced exclusion based on ethnicity. Madonna and Mariam shared stories of exclusion on their arrival in Canada, and challenges in achieving their professional goals as a result of credentialing issues, prejudice and racism.

Mark and John both indicated that their gender, while a handicap during their nursing education years, actually became a benefit for them during their nursing careers. Their gender created a certain visibility which has enabled them to move agenda items forward. Mark and John both indicated that their most powerful experience of being Other occurred during their time spent working in remote northern Aboriginal communities.

Katherine alone did not share experiences where she was in the minority. Perhaps because of the absence of personal experience, Katherine's approach to difference was

narrower in focus (addressing primarily Aboriginal and immigrant students), more pragmatic and less emotional than the approaches of the other participants.

***Inclusion: An Issue of Fairness, Function, and Participation***

The majority of the study participants saw inclusion as an issue of fairness, a moral issue with its roots in social justice. One study participant (Katherine) held a view of inclusion that focused more on function—that is, creating a nursing work force that reflected the population it served. While rooted in egalitarian beliefs, Katherine’s view of diversity was articulated as less a moral one, and more a pragmatic one than seen in the other participants. The contrast between these views was interesting, and bears further investigation to determine whether a moral, justice-based approach is more common in leaders who have experienced difference and exclusion personally.

Mark, John, Madonna and Mariam clearly articulated the importance of not essentializing culture. Madonna talked about “it’s about being us”. Mariam invited the white leadership of nursing to see diversity as including them. Madonna and Mariam expressed the need to view each of us as diverse human beings, not as members of certain cultures with laundry lists of prescribed characteristics attached. While Madonna felt that it was important to be inclusive, she also articulated the importance of honoring difference. Being a black woman was a powerful part of her identity, one that she was not prepared to have dismissed or minimized. Mark was critical of the way in which nursing education in general approached the issue of culture, from an essentialist position. Mariam and John also criticized the profession for its lack of openness to diversity. By contrast, Madonna and Katherine had a more optimistic view of the profession’s willingness to be inclusive.

***The Importance of Role Models and Mentors***

Several of these leaders (Mark, Katherine, Madonna) identified the importance of role models in inspiring marginalized people. They talked of the importance of diversity within the leadership of the profession in inspiring others, and in representing the Other. Many (Katherine, Mark) acknowledged the importance of creating a critical mass of diverse students, thereby creating a different norm in nursing education.



### ***Creation of Places of Safety for Those Who are Different***

John and Mark both used the word “safe” when describing the environment that they aimed to create on the nursing unit and in the classroom. Katherine’s story of disciplining a student who had made racist comments in front of an Aboriginal colleague described an attempt to create and convey a message about an environment where diverse students could feel safe from prejudice and discrimination.

In summary, these leaders shared many views on diversity. Most advocated an approach to difference that accommodated a broad view of diversity, and that honored the uniqueness of individuals, without mapping the stereotypes of minority groups onto them. They identified the need for the development of safety zones where all could be different and engage in discussion and celebration of difference without fear of reprisal. Most arrived at their interest in difference, diversity and inclusion through personal experiences of difference. For most, these experiences left them with a sense of unfairness and injustice, and resulted in an approach to inclusion based very much on social justice. Only Katherine did not come to her interest in difference from personal experience. There was a spectrum of beliefs about how open nursing was to embrace diversity, with Mark, John and Mariam believing there was little support, while Katherine and Madonna were more positive in their views.

### ***Leadership***

The stories of these leaders were analyzed with respect to the early influences in the lives of these leaders, and in relation to the five leadership subthemes of the study: Critical leadership, transformative leadership; educative leadership; ethical leadership and inclusive leadership.

### ***Early Life Influences: Impact of Family of Origin***

All of the study participants reported a middle class (Mark, John, Katherine) or upper middle class upbringing (Madonna, Mariam). In some form, all participants were raised with the belief that they could aim high and that they would succeed. All study participants indicated that their parents prompted them to plan for education after high school. Perhaps such explicit expectations contributed to the drive and the success of these participants.

### ***Critical Leadership***

Each of the participants addressed the following issues relating to leadership as critique in some way in their narratives: Power, conflict, humor and expertise.

**Understanding power.** Each of the study participants addressed the issue of power. They were all well aware of the power they held with respect to leadership and diversity. Many of them identified some of that power as coming from their visibility with respect to the issues they supported (Mark, John, Katherine, Madonna). They all possessed clear understandings of the historical and social contexts of power and how power impacted issues of diversity and inclusion within the profession. Most of them (Mark, John, Madonna, and Mariam) had personal experiences of exclusion based on their power in relation to the Center.

All of the study participants possessed a keen ability to reflect on the current state of diversity and inclusion within the profession. Most of the study participants reflected on their own experiences of exclusion in the profession. While Katherine did not recount personal experiences of exclusion, she described her own changing awareness with respect to the presence of Aboriginal people in her home community, and commented on their marginalization and their invisibility to her in her youth. All participants were able to reflect on the social and political history that brought the profession to its current state with respect to diversity and inclusion.

**Conflict: The inevitable.** Each participant spoke about conflict, its inevitability when dealing with issues of diversity and inclusion, and a leader's role in addressing it. Mark, John, Madonna and Katherine talked of the challenges faced by leaders in having the difficult conversations. Each of them talked about the difficulty nurses have in dealing with conflict. Madonna and Katherine talked of learning that procrastination in dealing with conflicts is counterproductive.

Katherine and Mark both spoke of the need to have a clear vision in dealing with conflict and to stand up to the vision— to “toughen up” as Katherine recalled the directive from her predecessor. Both Katherine and John made the point that leadership is not a popularity contest, and that making tough decisions can cause backlash for which the leader must be prepared. Having a solid vision allowed each of these leaders to avoid

reacting personally to negative situations. Having vision allowed them to keep their “eyes on the prize” and not be diverted by the attempts of those around them to keep them from achieving their goals.

Mariam and John talked about conflict, not at an interpersonal level, but at a professional level. Mariam talked about the reluctance of the profession to address diversity issues because of its desire to avoid discomfort. John’s view of the profession was one of a group that avoided change and conflict through its overwhelming capacity for conformity, and resistance of difference.

These stories revealed that addressing diversity results in conflict. However, conflict was not seen by these leaders as negative. Conflict made obvious the contradictions and opened the floor for dialogue which potentiated enhanced understanding.

**Humor: The great equalizer.** Mark, John and Katherine all identified the importance of humor in reducing tension and in allowing for the development of perspective. Laughter built relationships, reduced tensions, and allowed for time to regroup and formulate a plan.

**The importance of expertise: “I’m good at this.”** All of the leaders shared that they were confident of their abilities as nurses, and most indicated confidence as leaders. This confidence in their own expertise was very important to them in order that they be seen as credible nurses and leaders.

Mariam indicated that she saw herself less as a leader than the other study participants. Mariam also reported feeling the need to excel in the profession in order to belong. She described the need to be twice as good as her colleagues in order to be seen as equal.

John and Mariam both spoke of the dismissal of expertise that is common when those at the Center view those on the margins.

In summary, for these leaders, critical leadership involved understanding power, dealing with conflict, being comfortable with their level of expertise, and being able to laugh at themselves and the situations in which they found themselves.

### ***Transformative Leadership***

For these leaders, transformative leadership was about passion and vision. Not content with the status quo, they had a clear vision of what should be, and a passionate commitment to making that vision a reality.

**Passion: This is what makes me get up in the morning.** One of the most prominent themes in all of the stories was that of passion—passion for the profession, passion for clients, passion for inclusion, passion for social justice. Mariam’s passion was faith-based, driven by her strong Christian beliefs. Mark and John had strong emotional reactions to exclusion—their own, and the exclusion that they witnessed.

Katherine felt positive about the way that the profession was addressing the issues of diversity and inclusion. Madonna was also pleased with the progress. John, Mark and Mariam, however, were not satisfied. The flip side of the passion they felt for the issues, was the angst they felt at the lack of progress. “Can’t we do better?” said Mark. “We haven’t come a single step, in some ways” said John. Mariam declared “We can’t pass the buck anymore”. Even those who saw the positive in the current situation (Madonna and Katherine) saw the need to do more, and to keep the issue of diversity and inclusion front and center on the professional agenda.

**Vision: Seeing the direction, and sharing it.** All of the participants identified the importance of vision in leadership. For most of the study participants (Mark, John, Madonna and Mariam) the vision was one of social justice. Diversity and inclusion were viewed as part of that issue. For Katherine, her vision was focused more specifically on creating a more representative workforce. Katherine saw the need for transformation of the profession. Mariam, John and Mark articulated a commitment to a broader societal transformation, of which inclusion was an important piece.

### ***Educative Leadership***

Educative leadership involved creating and recognizing opportunities, being strategic, being engaged, and being an advocate. For the study participants, the role of a leader involved embracing the possible and engaging others in the mission to achieve these possibilities.

**Creating and recognizing opportunities.** For these leaders, their careers were spent recognizing and creating opportunities for themselves and for others. Mark, John and Madonna spoke of the importance of saying “yes” to causes, even at personal cost to themselves. Mark and Katherine also spoke of the importance of saying “no” when their colleagues simply were not ready to go where they wanted to take them.

All of these leaders recognized the opportunities provided by education. Each pursued additional education beyond an initial diploma or degree. Two participants had doctoral degrees (Mark, Madonna), while the remaining participants had master’s degrees. All of the participants identified their nursing educational experiences as pivotal experiences, with many identifying role models who influence them even today. For Katherine, her education experience was highly positive, while for all others the educational experiences were at times very painful, requiring tremendous personal conviction and strength to overcome.

These leaders did not just focus on opportunities for themselves. They viewed the world in possibilities for themselves and for others—possibilities to take positive action and make positive contributions. As such, they were ready and willing to take advantage of opportunities that presented themselves, or were strategic in their ability to create such opportunities. Mariam talked about her ability to generate opportunities to implement cultural competency training for all new employees. Mark talked about using his position as a faculty member to create opportunities for his students, and as an administrator to initiate programs and partnerships to enhance diversity in the profession. John talked about increasing diversity on the unit where he was manager by “just doing it”. Katherine talked about taking on virtually all programming opportunities that came up for her institution if they enhanced diversity within the profession. This practice of engaging the possibilities was an important aspect of the leadership provided by these leaders.

**Being strategic: Understanding the chess game.** All of the leaders interviewed talked about the importance of matching passion with strategy to accomplish goals. They all spoke of the importance of exploring different perspectives before settling on a plan of action. John described himself as a “thoughtful provocateur” encouraging nurses to explore new and different alternatives. Katherine talked about the importance of

maintaining relationships and networks in accomplishing goals, encouraging leaders to “bank goodwill” with colleagues for the times when support was needed for issues.

Mark addressed the importance of developing unique strategies to address particular diverse situations rather than a “lowest common denominator” approach, one that did not take into account the needs of individuals. He described the current approaches of the profession, particularly nursing education, as “mix and stir” rather than a strategic purposive approach aimed at meeting the unique needs of individuals.

Madonna and Katherine both spoke of the importance of perspective. While an issue might have seemed of the utmost significance at a particular moment, both leaders advocated a relaxed approach to priority setting. “Will this matter in a day, a week a month?” said Madonna. Katherine advocated, when making a decision about whether or not to take action in a situation, “What’s the worst that can happen?” Weighing the consequences assisted in deciding on the relative merits of a course of action, according to Madonna and Katherine. Perspective allowed these leaders to live with ambiguity and to let situations evolve, rather than trying to control them.

Mariam referred to strategy as a chess game. She identified the need to build a foundation of support that was broad as well as deep. Influencing the leader at the top was not sufficient. Building a broad base of support was necessary to enhance the sustainability of initiatives.

**Engagement: Being there.** Each of these leaders was intimately engaged in enacting vision. Mark talked of leadership as “...being fully engaged in the moment. It’s investing your life force, your energy, your creativity, and you’re bringing that to bear fully and wholeheartedly.” Madonna’s story of her involvement in the baseball tournament and her recognition of the importance to the organizers of her continued presence demonstrated the importance of engagement in achieving desired outcomes. All of these leaders were heavily invested in their commitment to diversity and inclusion, and they all demonstrated through their passion and their vision a commitment to ongoing engagement.

Such engagement came at a price. Mark, John and Katherine all identified that saying “yes” to opportunities was not without significant strain on personal health and functioning. John said, poignantly “I’m getting tired. Getting tired.”

**Advocacy: The job of the profession, and the job of a leader.** All of these leaders identified themselves as advocates for the issues of inclusion. They saw themselves acting as advocates for clients (Mariam), students (Mark) and the staff they supervised (Madonna, Katherine, John). Mariam indicated that the advocacy role that leaders played in relation to diversity and inclusion came directly from the underlying tenets of the profession. She said with respect to people of difference in society, “...we have an obligation as a profession and as nurses to protect them and advocate for them”.

### ***Ethical Leadership***

Each of these leaders exhibited commitment to ethical leadership. Ethical leadership involved building relationships based on trust, honesty and respect.

**Authenticity.** Many of the leaders referred to the importance of honesty in leadership. Katherine expressed distaste for dishonesty; a distaste that she felt was rooted in the ethical expectations of the profession. She practiced honesty, and expected it in return. Madonna’s approach to issues was one of openness and honesty. John also advocated honesty, but noted that “honesty isn’t always nice”. He advocated being honest, without being mean, or “honesty with a kind hand”.

### ***Inclusive Leadership***

All leaders spoke of inclusion as a goal of their leadership. Katherine spoke of her egalitarian, inclusive leadership style, but also spoke candidly of the dangers of such a style, because, ultimately, leaders had to make the hard decisions. Sometimes others were involved when it wasn’t appropriate, and sometimes when they were included the discussions went on too long. Katherine identified knowing when to stop discussion and make a decision as a potential pitfall for leaders.

### ***Professional Closure***

Four of the leaders discussed issues that relate closely to professional closure. Both Mark and John identified current practices in nursing that produced professional

closure. Both identified the move to baccalaureate degree as the entry to practice credential for nursing as a potential barrier for economically disadvantaged students, and for those who did not have a university tradition in their family background, a tradition that allowed them to understand and master complex education systems. John referred to the difficulty in getting people from diverse backgrounds into managerial positions because of their lack of the required baccalaureate degree. These two leaders also identified as professional closure the ghettoizing of Aboriginal people, visible minorities and immigrants in entry-level practical nursing positions, and the resistance by some nurse educators to the development of bridging opportunities for practical nurses.

Mariam addressed the challenges faced by immigrant nurses in having their credentials accepted, gaining admission to educational programming, and accessing employment.

Madonna spoke of her desire to advance her social position by completing nursing education. She looked for a profession that would provide status for a black woman in the Canadian context.

### *Summary*

This chapter included the constructed stories for each study participant, with commentary identifying the themes that arose in the narrative and relating the themes in narratives to those of other participants. At the conclusion of the narratives, a comparative analysis of the themes arising from all of the narratives was reported.

The narratives of each of these leaders contributed to an understanding of diversity and inclusion within the profession, and to the experience of critical, transformative, educative, ethical and inclusive leadership in the nursing profession. They also demonstrated the experiences of these leaders with professional closure.

The following chapter summarizes the study and its findings, and includes a detailed discussion of the study findings in relation to the literature. At the conclusion of the discussion, the implications of the study are identified. The chapter concludes with my reflections about the research process and its outcomes.



## **CHAPTER FIVE: SUMMARY AND CONCLUSIONS**

### **Introduction**

This chapter summarizes the study, reviewing the purpose of the study, the problem, the research questions and the methodology. I summarize the findings of the study in relation to the research questions, and discuss them in relation to the literature reviewed in Chapter Two. I continue with a discussion of the “so what” of the study—“so what” in relation to research, to theory, to policy, and to practice. I conclude with reflections on the insights that the study processes and findings have engendered for me, including a personal conceptualization of critical leadership in nursing.

### **Summary of the Research Design**

The impetus for this study came for my own 30+ year career teaching nursing students, and my concern that the makeup of the student body in the profession did not reflect the public that nurses served. I was concerned about the lack of tolerance of difference within the profession and how that played out in the disadvantaging of students who appeared different, due to their skin color, country of origin, language, sexual orientation, ability, or simply their non-conformist approaches to the profession. In recent years, in various leadership positions in the profession, I had the opportunity to influence policy development and creation of supportive environments for diverse students. I became very interested in how leaders in nursing viewed and influenced the agenda related to issues of difference and inclusion. The purpose of this research was to help us gain an understanding of leadership and the leadership roles of diversity champions within the profession as they aimed to increase diversity in nursing.

The study was built around the following research problem: What were the experiences and stories of nurse leaders who have increased diversity and inclusion within the profession through their leadership? The study involved five leaders who were known in the profession to have increased the participation of visible minorities, immigrants and Aboriginal people in the profession.

The following research questions guided to study:

1. How did these nurse leaders come to their current conceptions of leadership, and what were these conceptions?

2. How did these nurse leaders come to their current conceptions of diversity and inclusion, and what were these conceptions?
3. How might the range and variety of experiences and stories of nurse leaders be described with respect to leadership for diversity and inclusion within the profession and the relevant systems?

The study was guided by a critical social theory approach, looking at the literature describing the social, historical and political contexts of difference and inclusion in Canadian society, and seeking to understand the experiences that impacted the five leaders surveyed with respect to difference and inclusion. The interview questions were structured with a critical approach aimed at eliciting reflective discussion about the participants' experiences. The interviews were semi-structured, allowing for probing and pursuit of additional stories to illustrate the points made by the participants, and for clarification when warranted.

Interviews were conducted by telephone, except in one instance (Mark) when a video hookup was chosen by the participant as the desired interview method. I conducted two interviews with each participant, of one to two hours each. After each interview the transcripts were professionally transcribed, reviewed for accuracy by me, and then forwarded to the participants. Their clarifications and deletions were incorporated into the revised transcripts.

Upon completion of all of the interviews, I reviewed each of the transcripts in depth. I reviewed the transcript of the first interview prior to the second interview with each participant. I read each transcript twice more, once to refresh my memory of the interviews, and a second time to identify some of the "big picture" themes, thus began the process of analyzing the data. Following the second reading of the transcripts, I used NVIVO 8 software to code the data, completing the coding in relation to structure, function and themes of the narratives. I used the broad concepts of the study as the major coding themes: diversity, leadership and professional closure. As I coded, many (50) subthemes emerged under the thematic headings. Subthemes were then combined under umbrella themes. The major themes and umbrella subthemes formed a conceptual template which I then used to structure the participants' narratives, using their own

words. The narratives, serving as study findings, were then analyzed in relation to the major study concepts: diversity, leadership, and professional closure, and relevant sub-concepts. First, each narrative was analyzed individually. Ultimately, the narratives were analyzed comparatively.

### **Summary of the Research Findings**

In Chapter Four, the narratives were analyzed in relation to the study conceptual framework and emerging sub-concepts. In this chapter, the findings are summarized and analyzed in relation to the research questions of the study. A discussion of the findings, relating them to the literature, follows this section.

#### ***Research Question 1: How Have These Leaders Come to Their Current Conceptions of Leadership, and What are These Conceptions?***

The first portion of this section on the chapter addresses how these leaders came to their conceptions of diversity. The next section addresses what those conceptions came to be.

#### ***How Have They Come to Their Current Conceptions of Diversity?***

For four of the five leaders interviewed, conceptions of diversity and difference came from their own experiences of difference. Mark experienced difference as a member of a family struggling with debilitating mental illness and alcoholism, which made his experiences in childhood different from his friends. Both he and John experienced first-hand discrimination as male nursing students at a time when men were just beginning to increase in numbers in the profession. However they both agree that, once they finished their undergraduate education programs and were established in their careers, their gender actually served as an asset in their careers and in their visibility in moving their agendas forward.

John and Mark both shared that, while their battles to achieve equitable experience and recognition in their undergraduate programs and their early careers shaped their interest in difference as an issue, it was their experiences with poverty and social disintegration in remote northern Aboriginal communities that for both of them ignited their passion around issues of difference and exclusion.

Madonna and Mariam had personal experiences of being different. Madonna did not report experiences of difference in her childhood, but only as a young woman on her coming to Canada. While Mariam also came to Canada in her adult years and experienced prejudice and racism in her life and career here, she reported experiences of difference in her own country, as a Christian in a predominantly Muslim country and as a woman, widow, and single parent in a country where women had limited freedom and rights.

Katherine alone did not report coming to an interest in difference from personal experience. She reported some childhood exposure to other white European cultures, but admitted that the local Aboriginal population was invisible to her in her youth. Katherine's interest in and commitment to increasing diversity within the nursing profession arose from the institutional mandate of the college where she went to teach. With a stated mandate supporting success for Aboriginal and immigrant students, working in this institution sparked her commitment to diversity within the profession, and exposed her to the experiences of diverse students. Her ability to empathetically relate to the experience of students from underrepresented groups, and her personal relationships with Aboriginal professionals and diversity office staff, who became her friends, assisted her in developing her understanding of the experiences of Aboriginal and immigrant students.

In summary, the primary motivators for these leaders in sparking their interest in difference were personal experiences of being perceived as different (Mark, John, Madonna, Mariam) and exposure to the experiences of marginalized groups within society and the profession (Mark, John and Katherine).

### ***What were Their Conceptions of Diversity?***

Within the group, there was a broad range of views of diversity. At one end of the spectrum was Katherine, whose views on difference, while based in underlying values of equity and fairness, focused mainly on the experiences of difference in relation to culture, ethnicity, language and nationality. Her approach to issues of difference was largely based on functionally increasing opportunities for underrepresented groups, with a goal of transforming the profession into a more representative workforce.

Madonna conceptualized difference from a social justice perspective. She saw exclusion as the experience of many groups in society—the poor, individuals who are gay, lesbian, bisexual or transgendered, the disabled. Her visibility as a black woman resulted in the perception by others that her work is focused on race, ethnicity and culture. She was quick to point out that she rejected the categorization of “It’s all about race”. Her mantra when speaking to all audiences of any race, ethnicity or culture is “It’s about people, it’s about being us”. However, she did not dismiss the importance of race. Being a proud black woman was an important aspect of her identity.

Mark, John, and Mariam all viewed the topic of diversity and difference in the nursing profession as an issue of social justice. For them, promoting inclusion in nursing is one action in the creation of a fair and just society. They each articulated a transformative vision of an inclusive society. Mark and John talked about the importance of creating safety zones where participants could feel safe, respected and free to individually and collectively explore their views and experiences.

Mark adamantly rejected the essentializing views of culture that are currently a part of nursing. He saw them as focused on the nurse and the nurse’s understanding of the expected roles and norms ascribed to a certain culture. He advocated a cultural safety perspective which focused on the experiences of the marginalized and the historical and social relations that have led to their marginalization.

Mariam rejected any ascribing of characteristics on the basis of culture, ethnicity, race, nationality or language, advocating an “n of 1” approach—the exploration of experiences, beliefs and values of each individual, free from any overlay of cultural expectations.

John and Mark both articulated a view of difference in nursing beyond issues of culture, ethnicity, language or nationality. They addressed the lack of willingness of the profession to address what John calls *diversity of thought*. They were critical of the profession for its drive for conformity and requirement of sameness.

Four of the leaders (Mark, John, Madonna, and Mariam) related stories of professional closure—situations where the profession erected barriers to admission in order to limit access and maintain the status of the profession. Acts of professional

closure included lack of support for bridging programs from practical nurse programs into baccalaureate programs, the move from diploma to baccalaureate education, the creation of arbitrary entrance and registration requirements, the downgrading and devaluing of educational credentials earned in other countries, and the limiting of minority nurse participation to front line positions without opportunity to rise into managerial and leadership positions.

### ***Research Question 1: Conclusions***

The study participants all expressed understandings of the issues of difference within the nursing profession from perspectives of both fairness and function. Most of them did not limit their view of diversity to issues of race, ethnicity and culture, but embraced a broad view of diversity that incorporated gender, sexual orientation, ability, and general non-conformist behavior or “diversity of thought”. These views were formed through personal experiences of being treated differently, as well as experiences with diverse groups who were marginalized in Canadian society.

### ***Research Question 2: How Have These Leaders Come to Their Current Conceptions of Leadership, and What are These Conceptions?***

The first portion of this section of the chapter addresses how these leaders came to their conceptions of leadership. The section following addresses what those conceptions came to be.

#### ***How Have These Leaders Come to Their Current Conceptions of Leadership?***

All of these leaders came to their conceptions of leadership through experiences early on in life. Many of them reported having taken on formal and informal leadership roles in childhood, adolescence and during their university days (Mark, John, Katherine). Despite their vastly different backgrounds, each of the study participants were raised in homes where there were *expectations*. These expectations might have involved succeeding (Madonna), contributing to the social good (John) or attending university (Mark, Katherine, John). In Mariam’s case, the expectations related to what she should *not* do—enter nursing. Being raised in homes where there were expectations set each of these individuals on a course where they considered from a very early age what their responsibilities were to and in the world. That sense of responsibility to someone and

something beyond self and immediate family was evident in each of these individuals' stories.

Each of these leaders had pivotal experiences with people who impacted their views on leadership. In some cases these were personal experiences. In other cases they were professional role models such as national nursing leaders or leaders with whom they worked on a daily basis. In some cases they were educators who influenced them during their nursing education.

Some of the role models were public figures. John's admiration for Pierre Trudeau's "just watch me" attitude created a belief in possibilities that affected John for life. Madonna's reverence for Barrack Obama and his ability to focus on the issues and not respond to personal attacks influenced her in her daily work.

Not all of their experiences with leaders were positive. John recounted a volatile confrontation with Kelly Munroe over power issues. Katherine's experience with her previous supervisor who bowled over the faculty on her way to achieving her mission was another negative experience. But the study participants all believed that such incidents made them better leaders, by increasing their resolve, broadening their understanding of issues, or highlighting areas where they needed to develop their skills.

### ***What are Their Conceptions of Leadership?***

These leaders' views on and experiences of leadership were addressed in relation to the study conceptualization of leadership: leadership as critique, transformation, education, ethics and inclusion.

**Leadership as critique.** Each of these leaders viewed leadership as a reflective process, one that required an understanding of the social, historical and political factors in the leadership context. Leading within context was an important aspect of their success as leaders. Leadership based on critique required an understanding of the context and the dynamics of that context, in the past, in the present, and in the future.

The leaders were all aware of the power relationships in their leadership contexts, and how their power played out. They all expressed a desire to understand power with the hope of increasing their ability to positively influence the agendas in their leadership contexts.

Mark identified the power that nurse educators have over all students, but especially those from marginalized backgrounds. Madonna, the recipient of misuse of this power in her nursing education, brought credence to his view. Mariam spoke of the power of health care professionals to marginalize and dismiss the knowledge of clients and their families.

Mariam worked from a model of shared power, based on leadership that served others. Mark, John and Madonna all identified their visibility within the profession as a source of power. They all admitted to using that visibility to further the cause of increasing diversity within the nursing profession.

Power imbalances give rise to conflict, a fact that all of the study participants identified. In some cases this conflict arose out of fear. John described the fear that increasing neighborhood diversity engendered in his parents, despite their seeming belief in equality and fairness. Mariam was the recipient of that fear reaction when she experienced her colleagues' shunning behavior at the time of the Gulf War and 9-11 because of her "Arabness". Mark described the language of diversity as imbued with fear.

Conflict was experienced at the interpersonal level, vertically within nursing structures, as evidenced by John, Mark and Madonna in their negative experiences with professors. It was also experienced laterally, as evidenced in Katherine's description of the racist behavior of a student in front of her Aboriginal colleague.

Mariam also described conflict at a professional structural level in her discussion of the resistance of the profession to diversity, because of the discomfort that difference engendered. John also described conflict at a professional level when he addressed the resistance of the profession to entertaining diversity of thought and to abandoning its requirements for conformity and sameness.

Humor played a significant role in addressing conflict and retaining perspective. Self deprecating humor was the hallmark of a number of these leaders (Mark, John and Katherine). Humor was seen as "a healing salve for the soul", a potion to counteract much of the negative "stuff" of leadership positions, an avenue for building perceptions



and increasing understanding. These leaders saw that humor, when shared, built a sense of community.

All of the leaders acknowledged that confidence and competence were essential to successful leadership. It was important to be viewed as competent by one's colleagues. This was especially important for those who were perceived as different by their colleagues in the profession. Confidence was necessary to sustain one's self as a leader during times of conflict.

**Leadership as transformation.** Each of these leaders was imbued with a passionate commitment to the profession, to the community it served, and to inclusion as a core value of the profession. Each professed pride in the role that nursing played in the lives of its clients. Each was passionate in the desire to increase the participation of diverse groups and individuals in the profession.

Coupled with this passion was clear vision. The vision expressed by these leaders was a transformative one, a vision based on addressing the inequities of representation of the past, and creation of a new future based on inclusion. For some this was seen as a vision for the profession. For others, fostering inclusion in the profession was a part of a larger plan to transform society.

The downside to a passionate vision for the future was the disappointment, disillusionment and angst felt when this vision was slow to come to fruition. This frustration was evident for three of the leaders: John, Mark and Mariam. While still passionately committed to the profession, they challenged it: Can't we do better than this?

**Leadership as education.** Each of these leaders saw leadership as an educative process. They spoke of the importance of leaders as mentors, and as advocates. They also saw leadership as creating and recognizing opportunities. Each of these leaders had recognized opportunities for themselves, with respect to educational and employment opportunities that allowed them to pursue their interests, develop their skills, and work with dynamic leaders in the profession. Leadership entailed creating opportunities for others as well, such as nurturing a marginalized nursing student who might not have survived the education program without someone recognizing her gifts and becoming her

advocate, or mentoring a colleague in decision-making around a career change. Opportunity presented itself as a result of policy discussions aimed at developing best practice guidelines for nursing practice, cultural diversity committees in an educational institution or cultural competency training in institutional settings. The matching of a transformative vision with the ability to make opportunities happen was a hallmark of all of these leaders.

Advocacy, mentoring, and the process of creating and recognizing opportunities all require engagement with followers. These leaders were all actively engaged in their leadership contexts, working closely with their colleagues to bring life to their vision. These leaders also recognized the importance of being strategic in their leadership. They identified the importance of not getting out too far ahead of the group, of staying close and working with others to “infect them with your passion”.

**Leadership as ethics.** For these leaders, leadership was an ethical, relational practice. It required honesty, openness and respect. Leadership was a moral practice, based on values of equity and fairness. It required confidence, tempered with humility, and a belief in the basic goodness of people.

**Leadership as inclusion.** Leadership was a shared process for most of these leaders. Mariam’s shared leadership was based on a belief in service that emerged from her strong Christian beliefs. Katherine identified the delicate balance of shared leadership, when ultimately decisions must be made, and the leader must make them.

For all of these leaders, inclusion was both a process, and also a goal. Ultimately they were all committed to increasing inclusion in the nursing profession.

### ***Research Question 2: Conclusion***

The stories of these leaders supported the conceptualization of leadership as a critical, transformative, educative, ethical and inclusive process. Each of these leaders, through their passion, vision, positivity, endurance, advocacy and mentoring were able to engender in their colleagues a commitment to action and a willingness to engage in the possible.

***Research Question 3: How Might the Range and Variety of Experiences and Stories of Nursing Leaders be Described with Respect to Leadership for Diversity and Inclusion Within the Profession and the Relevant Systems?***

In this study, the range and variety of experiences of these leaders for diversity was described in narrative form. Their words and experiences were woven into stories that were intended to capture the power of their experiences and to share those experiences with the reader.

Mark's painful experiences of difference in his family of origin were depicted in detail. The picture of a child dutifully recording his mother's accounts of her visions and taking these accounts to the post office to be mailed to the Pope formed a powerful image of the isolation experienced by those whose lives are different. Views of Mariam eating alone in a large bustling hospital cafeteria completed the picture of isolation.

One visualized Madonna returning to the nursing program after her failure in the practicum, proud and determined to succeed. One saw Mariam seated, nervous but outwardly calm, in front of a panel of thirty people, speaking to them in her perfect, accented English, explaining to them her experiences of life in a war-torn country. The pictures painted by these stories paid homage to the tenacity of people who are underrepresented in the nursing profession and their attempts to gain access to and succeed within its ranks.

The story of Mark in the classroom with his nursing students, when a timid shy student rose to her feet and sang a poignant song that she had written herself, left us with a picture of hope and possibility. The astonishment on the faces of her classmates, and the pride on Mark's face were visible to us.

Views of John, in front of a large gathering of women, working closely with a matron in the group to show her how to send a text message, gave testimony to his desire to educate nursing leaders in new ways of thinking and doing.

This study used the power of stories to depict the challenges faced by those from underrepresented minority groups who dared to enter nursing, and the challenges and joys faced by leaders in nursing who worked hard to make their entry a success. Stories formed the basis of the description of the experiences of these leaders.

### Discussion of the Findings

Everything to this point in the study has contributed to the “what?” of the study. What were the conceptions and experiences of leaders regarding diversity? What were their conceptions and experiences around leadership? What did the literature say about leadership or diversity in nursing? In this section I leave behind the “what?” of the study, to address the “so what?” of the study. This section discusses the relevance of the study findings in relation to the research problem: What were the experiences and stories of nurse leaders who have increased diversity and inclusion within the profession through their leadership? In the following section, the experiences of these leaders are discussed in relation to the literature reviewed for the study. I also view the experiences of these leaders and the literature reviewed for the study in relation to my own experiences as a nurse leader with experience in increasing diversity in the profession.

#### *“So what” about diversity?*

Chapter One discussed the promotion of diversity in the health professions as related to two issues: fairness and function (Nickens & Smedley, 2001). The fairness argument maintained that many racial and ethnic minorities were traditionally excluded from economic and professional opportunities. Mechanisms were necessary to recruit and retain health professionals as a mechanism of redress for such exclusions. The functional argument maintained that the needs of minority groups could best be met by members of their own culture, ethnic or racial group. Participants in this study professed both views, but more were driven by the fairness view of diversity, in the larger social justice perspective. Kirkham and Anderson (2002) advocated a *parity of participation* perspective, allowing for both fairness and function. They argued that, in a just society, all adult society members should have the opportunity to interact with each other as peers. This approach corresponded with my own rationale for inclusion of underrepresented groups in the profession, and my motivation over the years in attempting to increase the participation of minority students, particularly Aboriginal students, in the profession.

The prevailing finding of the study with respect to diversity and difference was that for most of the leaders, difference was a created, socially stratified process that

created and perpetuated systems of inequality for the purpose of advantaging a dominant societal group at the expense of others (Johnson, 2006; Ore, 2006; Winterdyk & King, 1999). While some of the study participants focused on difference related to culture and ethnicity, for most it was broader than that. The broader approach seen in some participants corresponded with critical multicultural approaches, based on social justice (Dewey, 1936; Freire, 2000) and democratic leadership (Furman & Starratt, 2002) referenced in Chapter Two. These approaches corresponded with my own personal approaches. It was through a social justice lens that I personally viewed issues of diversity and difference.

Ceci (2006) discussed difference as a relational construct, with alternate meanings in different contexts. Mariam exemplified this relationality. She was alternately advantaged by her British-like accent, in one instance, and disadvantaged by her skin color and ethnic name, in others. She was unchanged. The interpretations varied.

I found John's view of the importance of *diversity of thought* most instructive here. I have experienced in my own leadership the resistance to possibilities that he identified, and shared his frustration and angst. I was intrigued by John's view that the life and death nature of the work that frontline nurses do precluded their ability to participate in visioning at a professional level. This corresponded with Katherine's view that her faculty members were too deeply engaged in the day-to-day and that having a vision, and a big picture view were her responsibilities as a leader. It was not really clear what the implications of these views were for Katherine and John with respect to involving staff in generation of a shared vision. This raised questions for me: What is the role of frontline staff in creating and unfolding the vision of an organization, and how much should they be expected to understand about the vision and the context in which the organization acts? In my experience, there has been a considerable role for frontline staff in setting and sustaining the vision of an organization, and, in fact, failure to involve them has doomed organizations and initiatives to falling short of their vision. It is for this reason that the educative aspect of leadership as defined by Foster was so important, and why Foster's approach resonated for me in mapping out this study. Foster saw the role of the leader as one that "attempts to raise the followers' consciousness about their own

social conditions, and in doing so to allow them, as well as the ‘leader’, to consider the possibility of other ways of ordering their social history” (Foster, 1989, p. 54). As several of these leaders noted, it was important as a leader to stay connected to colleagues and to share the leadership vision and the development of that vision with them.

John’s view of the lack of diversity of thought in the profession referred us back to the concept of marginalization, where margins were defined in relation to the Center, producing a binary Center-Other. The Center in nursing included the powerful mainstream of “white middle class women from the suburbs”. There was a powerful process of social exclusion and pressure to conform at play at the Center in the process of marginalization, and within this process there was little tolerance for thinking that deviated from that of the mainstream. Gustafson’s concept of the “white, good nurse” supported John’s view of expectations of conformity. The white, good nurse accepted the taken-for-granted assumptions of the dominant view and conformed to them (Gustafson, 2005). John’s stories of the inability of the nursing leadership at a large metropolitan hospital to entertain the possibility of the use of technology were an example of the lack of tolerance for diversity of thought.

Katherine’s story of the invisibility of Aboriginal people in her home community also illustrated the process of marginalization. Because Aboriginal people were not visible within her social structures, such as school, church and local neighborhoods, they were not part of her social experience. This personified on an individual level the social process of marginalization whereby the marginalized are invisible to those at the Center (Vasos, 2005).

...marginalized peoples are invisible to those at the Center because they are not present in their immediate environments...Therefore, their needs and voices are often not heard by those in the Center...privilege nurtures blindness toward those without the same privilege. (p.196)

This incident also exemplified heterogeneity as a social characteristic, as outlined by Winterdyk and King (1999). In a heterogenic society, members of larger social groups experienced few interactions and were less experienced at interaction with smaller social groups.

Mark and John both spoke of the fear in their families and colleagues engendered by difference. Mariam experienced fear from the other end of the spectrum when she was shunned by her colleagues during the Gulf War and 9-11. The generation of fear in the context of dealing with people of difference was explained in the review of the literature as an aspect of the concept of Othering. Othering differentiated between groups based on their relationship to the dominant group. As noted in Chapter Two, Othering served to magnify difference and reinforce positions of domination and subordination (Johnson et al., 2004). By the process of Othering, “identity is assigned, human existence is categorized, people are characterized according to certain criteria...and experiences are homogenized” (Reimer Kirham & Anderson, 2002, p.6). Defining the Other created a separation and the conditions for generation of fear, based on that lack of familiarity and lack of understanding.

The personal experiences of difference shared by the leaders in this study were powerful. Comparing their experiences to the literature, there were many similarities. Mariam's stories about the pressure she experienced to be better than others, in order to be considered as good, reflected the themes outlined by Giddings in her study of ethically diverse nurses in the U.S. and New Zealand. Giddings' (2005b) overarching meta-story was one of *not fitting in to nursing*. Mariam's stories effectively illustrated two of Giddings' subthemes: *experiencing unfairness* or “not being quite suitable” (Mariam's experience with the supervisor who initially declined to hire her because she was “overqualified”) and *trying to survive*, as evidenced by her need to excel in the completion of qualifying courses in order to gain access to graduate studies. Recent research by Das Gupta (2009) indicated that nurses of color were often held to higher standards as far as competence was concerned. This also reflected Madonna's beliefs about her differential treatment in having to repeat a clinical course when other non-minority nurses were not required to do so. The need to prove oneself repeatedly was reported in recent studies as a common experience of minority nurses (Alexis & Vydelingum, 2007; Xu, 2007)

Katherine's story of the incident involving racist comments uttered about Aboriginal people by a student in the presence of another student mirrored the

experiences of Aboriginal students as outlined in the review of the literature (Martin & Kipling, 2006). It also mirrored many student experiences witnessed during my own career.

While Katherine recounted a story wherein she was unjustly accused of racism, she did not share any stories where faculty members had actually displayed racist attitudes. I wondered if this was because she set such clear standards with respect to inclusion and cultural sensitivity that such behavior just didn't happen, or whether she chose not to share those stories with me.

Her insight in recounting the story of her experience of being accused, of racism demonstrated Katherine's strong sense of herself in choosing not to take this situation personally, and recognizing the individual's need to maintain some control in this situation. I have also been in this position, and recognize the pain that such occurrences cause. I have been accused of prejudice by students who were appealing failing grades and had to examine in each instance whether I was being fair in my expectations and had provided the appropriate supports to assist the students. Katherine and Madonna both talked about the need to avoid taking things personally in such situations. In my experience as a leader, this was one of the most difficult lessons of leadership, but also one of the most important and most beneficial.

The participants who were not born in Canada, Mariam and Madonna, both recounted stories of difficulty in having their credentials recognized in this country. Mariam also recounted stories of exclusion in the workplace. These experiences mirror those of immigrant nurses as seen in the literature in Chapter Two (Coffey, 2006; Hagey et al. 2005; Jeans, 2006; Lebold & Walsh, 2006; McGuire & Murphy, 2006; Turritin et al., 2002). Difficulty with credentialing and registration, prejudice, and difficulty integrating in to the workplace were all identified as challenges for immigrant nurses in Chapter Two. Such difficulties were viewed as contradictions to the rhetoric of freedom and opportunity commonly seen as part of Canada's advertised approach to multiculturalism (Lyman & Cowley, 2007) and sought after in coming to Canada by immigrants such as Madonna and Mariam.



Issues with credentialing, dismissal of the relevance of past international experience, and distrust of her motives in seeking employment resulted in Mariam feeling disrespected and not valued. These were common feelings reported by internationally educated nurses, according to Socan and Singh (2007).

Mariam's story of the lack of mail service in her home country and waiting patiently for credentialing documents to come from her homeland with relatives who were traveling back and forth to Canada mirrored the experiences of many internationally educated nurses in the literature. Her determination was a testament to the tenacity required by internationally educated nurses in order to succeed in accessing the profession in Canada (Lebold & Walsh, 2006; McGuire & Murphy, 2006; Turriffin et al., 2002).

The male participants, Mark and John, reported experiences of prejudice and differential treatment based on their gender during their nursing education and early in their careers. However, they indicated that eventually in their careers the visibility provided to them by their gender did not disadvantage them, and in fact served to give wings to issues they were attempting to move forward. Their experiences are supported by the literature referenced in Chapter One which indicated that men in nursing did not experience the same power disadvantages as other underrepresented groups in the profession (Evans, 1997; Evans, 2004; ICN, 2004; O'Connor, 2003).

While I was aware that men in nursing experienced challenges, Mark's discussion of the sexualized nature of men's touch in the profession, and his story of the man who left the program in his third year because of his discomfort with the intimacy of the care he was required to provide, challenged me to look at my own history in teaching men in the profession, and to recognize that I had not addressed their specific learning needs, nor had I provided leadership in my formal positions in nursing education to ensure that other educators knew how to address the needs of male students in the profession. I had been guilty of what Mark called the "mix and stir" approach to the special needs of males in the profession. While addressing the role of men in the profession was not the central focus of this study, the stories told by Mark and John of their experiences demonstrated

the importance of looking at issues around difference in the profession in the broadest of contexts.

Mark and John both spoke passionately of the importance of creating safety zones for people of difference where they could safely explore their experiences with an expectation of respect and security. Providing a safe environment was the cornerstone of the concept of cultural safety, wherein nurses were charged with the responsibility of protecting and maintaining a culturally safe environment for their patients (ANAC/CASN/CAN, 2009; Smye & Browne, 2002).

From Mariam's perspective, the white leadership in nursing failed to take up the issues of difference and inclusion because they did not see it as being "about them". Diversity was about somebody else. This corresponded with Campesino's view as discussed in Chapter Two, where whiteness was the "invisible de facto norm" (2006, p. 302), and with Culley's discussion of the underlying belief that white is not an ethnicity (Culley, 2006). This failure to address difference occurred because nursing leadership found the issues around difference and inclusion "uncomfortable", according to Mariam. Leaders preferred to believe that there were no issues around difference, a position that Shields (2004b), speaking specifically about issues of racism, described as "color-blindness". Shields viewed such a position as hegemonic, one that only people of the dominant discourse had the luxury of having. Shields saw that such views gave way to pathologies of silence, where difference was pathologized and not spoken about. Shields' view was supported by Mariam's story of nursing silence and dis-ease about difference.

Mariam's resistance to the essentializing of differences corresponds to Kirkham and Anderson's (2002) on Othering, which they defined as "...an act of representation by which identity is assigned, human existence is categorized, people are characterized according to certain criteria... and experiences are homogenized" (p.6). It was this categorization, characterization and homogenization that Mariam described with such eloquence, and resisted with such passion.

In Chapter Two, Canales articulated a positive concept of Othering—that of Inclusionary Othering. Inclusionary Othering necessitated taking on the role of the Other, a process similar to empathy or insight (Canales, 2000). This was the process that

allowed Mark and John to engage with the Aboriginal communities in which they worked, and that allowed Katherine to understand the experiences of diverse students.

Inclusionary Othering was an important concept because it validated the involvement in meaningful discourse and action around the issues of difference and inclusion of those who had not actually had the lived experience of difference. The ability to empathize was an important aspect of my own experience as a white, middle class woman when dealing with students from diverse backgrounds. My ability to empathize was heightened as my familiarity and comfort with people of difference grew. I recognized the importance of involving myself on a regular basis with people who had very different backgrounds than I did, whether through choosing to live in a multicultural neighborhood and involve myself and my family in community life, or engaging in community health experiences with nursing students in a remote Aboriginal community. Katherine advocated for increasing the involvement of nursing students in communities of difference, communities that celebrated and acknowledged difference. Shields (2004a) advocated the celebration of these differences at a critical level, invoking understanding of the political forces that have separated social groups in our society. My personal and professional life experiences have also been directed at creating and sustaining communities of difference.

### ***“So What” About Leadership?***

For each of these leaders, leadership was relational, not positional. While Katherine’s approach to leadership related more to her current formal leadership position than did the others, all of these leaders saw leadership as a process of building relationships and of collective action. Leadership for them was far more than a positional responsibility.

### ***Leadership as Critique***

Foster (1989) advocated critical reflection as an integral aspect of critical leadership. Critique included both reflection and dialogue, dialogue conducted at a moral level (Shields, 2004b). Each of these leaders demonstrated the ability to reflect critically on historical, social and political processes and structures in their experiences that have produced the exclusion of people of difference from the profession. For example, Mark

and John reflected on the social structures and power relationships that lead to the historical exclusion of the Aboriginal people from decision making about their futures. Such critique is the essence of critical leadership, as defined by Foster (Foster, 1986; Foster, 1989). Foster said of critique in leadership

...this challenge necessitates both a close examination of personal beliefs, coupled with a critical analysis of professional behavior. It requires the problematization of those taken-for-granted practices that we no longer notice, unless we are specifically asked to do so. (p.703)

In this study, these leaders were asked to do so, and provided rich reflective stories about the nature of the profession in relation to difference and inclusion as a result. This reflection was approached from a critical perspective, one that looked at the “historically determined social structures that constrict free consciousness and serve the interests of only some individuals” (Foster, 1986, p.57) Reflection allowed these leaders to grow in their leadership. Reflection and critique allowed them to avoid what Foster described as leaders who “wield power on behalf of static ideals” (Foster, 1989, p.51).

Each of these leaders identified the importance of the profession understanding the context in which it found itself. They each talked about the profession, the power relationships within the profession, and power in relation to the larger community. Katherine talked about the profession’s propensity to eschew discussions of power and political influence. Her view of the profession as disdaining of power and politics supported the findings in the review of the literature that nursing as a profession was minimally involved in sociopolitical activities at any level (Ballou, 2000) or avoided political action altogether (Hardill, 2006), and that nurses traditionally supported the existing social order (Falk-Raphael, 2005). Katherine described this position as a “cocoon”, a metaphor that is used also by Sue Donaldson, Dean of the School of Nursing at Johns Hopkins University, as cited in Villeneuve and MacDonald (2006). Donaldson challenged nursing to move beyond its insularity and inward preoccupation, or risk becoming an “expensive cocoon” (p. 93). The image of a cocoon, with its closed outer shell, resonated with the conceptual diagram of the framework of this study in Chapter Two, where professional closure functioned in a limiting, cocoon-like fashion to enclose and isolate the profession.

Katherine articulated a view of leadership that required an understanding of power and politics. She rejected the political invisibility of nursing described by Antrobus and Kitson (1999), speaking passionately about the role of the leader as a translator—a translator of the broader vision to those in the front lines, and a translator of the profession and its clients' needs to the senior policy makers around her. Her description of her actions as a leader in translating the needs of the department and its programs to senior administration, government and the public was an example of making “the invisible visible” in the vernacular of Antrobus and Kitson (1999). This translation process was reflective of my own experiences as a leader. As I indicated in my discussion of the importance of narrative in my nursing career, I have often used the stories of nursing and its clients to increase understanding on the part of senior officials and to translate budget requests and business plan submissions into propositions with meaning to important decision makers.

In order to influence the profession, each of these leaders identified the need to understand power relationships and sources of power within and beyond the profession. They sought to understand power relationships not for purposes of power wielding, where, as Foster (1989) indicated, the task is the end and the people simply a means to accomplish the task. Understanding of power was necessary in order to move toward transformative goals.

Each of these nurses spoke of their desire to influence the direction of the profession, some in broad and sweeping ways, and others with a more focused interest on diversity and inclusion. Katherine talked about the importance of being positioned in the profession so that she could have influence to ensure a strong ethical focus in the development of clinical skills and decision making in nursing students. Mark, John and Madonna talked about using their visibility as people of difference within the profession to further their agendas. Influence was a relational concept. Influence was achieved by dialogue and reflection, not by “pulling rank” or by overpowering the discussion. The desire to influence was a theme that resonated with me as I too have always sought out positions that allowed me to contribute to the development of the nursing profession as an ethical force in health care and society.

The review of the literature showed that influence was possible when leaders were viewed by their colleagues as legitimate members of the group with demonstrated expertise in the field (McFadden et al., 2005). Each of these leaders spoke of the importance of being experts in the profession, and of being seen as experts. Those with backgrounds of exclusion (Mariam) spoke of the importance of being more than excellent in order to be seen as competent. For Mariam, this was necessary to prove to others that she belonged.

Power dynamics within a profession often give rise to conflict. Kelly (2006) indicated that there was "...an almost stereotypical expectation that nurses should not engage in conflict as people prefer nurses to have warm, kind and sympathetic personalities" (p. 23). This harkened back to Gustafson's view of the "good nurse" (2005). These leaders had all expressed challenges managing conflict. Indeed, several of them identified their need to learn in their career not to avoid the difficult discussions.

Kelly indicated that conflict arose as a result of differences in ideas, values or feelings (Kelly, 2006). Conflict was especially prominent when racism was present. Racism was found to exacerbate team conflict and miscommunication (Dreachslin, Hunt & Sprainer, 2000).

Conflict however, was inherent when taken-for-granted assumptions were being challenged. Conflict was necessary in order to prompt the seeking of understanding that occurred with dialogue and critical reflection (Pettrey, 2003). Each of these participants agreed that, while it was uncomfortable, it was important that leaders address conflict. Several of the leaders identified the importance of not taking conflict and discord personally, but recognizing it as a part of the transformative process. Conflict is discussed further in the following section which addresses leadership as a transformative process.

Many of these leaders identified humor as a significant mechanism in dealing with stress and conflict in leadership positions. They reported that humor diffused tense situations and allowed for the development of perspective. These findings were reflected in the literature. Reese (2009) maintained that humor built bonds between people. She quoted the late pianist and comedian Victor Borge as saying "Laughter is the shortest distance between two people". These bonds between people built trust, nurtured

communication, supported creativity, and reduced tension. Holmes (2007) cited research demonstrating that humor in the workplace improved productivity, facilitated teamwork and collegiality, boosted morale, helped employees cope with challenges, motivated and supported employees, and improved job satisfaction. These findings were of special significance to me, as humor has always played a significant role in my life and work. I have frequently chosen to use humor to put people at ease and to “level the playing field” by demonstrating my desire to engage on a personal level in situations of potential conflict. When used appropriately, humor has been a powerful leadership tool in my leadership experience.

### ***Leadership as a Transformation***

Foster saw leadership as inherently a transformative process, one that “...communicates message and symbol beyond our current achievements: it provides a vision, a vision of a just and equal social order” (1986, p.188). Each of these leaders had a transformative vision for the profession. Shields talked of transformative leadership, rather than transformational leadership, which she viewed as restricted to change within organizations. Transformative leadership looked beyond organizations to the need for change at a societal level (Shields, 2004b). Most of these leaders situated their leadership within the broader context of social transformation.

The review of the literature around leadership acknowledged the importance of passion in leadership. Pence (2003) identified this passion as a sense of *calling* or leadership as *vocation*. Inherent in the term vocation was knowing “who one is, what one believes, what one values, and where one stands in the world” (p 39).

These leaders all embodied passion for the profession, and for the issue of inclusion within the profession. But with that passion, for some, came dis-ease, and discomfort with the current state of affairs. It was passion, and its flip side, angst, that supported and fueled these leaders in the transformation of the systems around them. The role of passion for these leaders was supportive of Foster’s view of passion and transformation (Foster, 1989).

Vision was seen as integral to transformative leadership. Pence’s discussion of visioning identified the need to “introduce a constructive restlessness instead of a

comfortable satisfaction” (p.185). The literature review revealed an aspect of transformative leadership that addressed the creation of *moral discomfort*. Brown’s discussion of leadership for social justice identified the importance of *values in action*, whereby leaders were willing to “leave the comforts and confines of professional codes and state mandates for the riskier waters of higher moral calling” (2006, p.702).

Thus the conflict addressed in the previous section emerged as a natural occurrence as these leaders pushed their followers to see things beyond the horizon. Conflict occurred when transformation was resisted in favor of the safer ground of the known. It occurred as a result of self-interested comfort in and commitment to the unjust power distribution in the existing social order. Mariam’s story of the resistance experienced when conducting workshops on cultural competence demonstrated a resistance to transformation and a commitment to the existing social order.

Brown (2004) supported these leaders in their view that learning to address such conflict was an important skill in transformative leadership. Brown advocated the development of “...the vocabulary, skills, and knowledge necessary to engage in substantive discussions concerning the dynamics of difference” (p. 80).

John and Mark’s frustration at the resistance to diversity of thought echoed the constructive restlessness (Pence, 2003) and moral discomfort (Brown, 2006) seen in the literature. John also demonstrated a slightly ominous degree of disillusionment, in his statement of fatigue (“I’m getting tired -- getting tired”). He lamented the propensity of the profession to get caught up in the challenges of the day-to-day, and believed that visioning is vital to the success of the profession. His view of the importance of vision clearly corresponded with Foster’s view of leadership as a transformative process.

Katherine’s view of the importance of vision correspond to that of Pence (2003), who saw the development of vision in leadership as requiring occupational skill, knowledge of organizational processes and structures, and a general level of expertise, but also the development of beliefs and values that promote individual and common goods (p.185).

Mark’s view of transformation was one of action, leaving behind the passive “mix and stir” remedies of the past. This action orientation fit with Freire’s view of



transformation and social justice as an active process, involving "...advocacy, solidarity, an awareness of social structures of oppression, and critical social consciousness" (Freire, 1994).

### ***Leadership as Education***

Foster described the importance of leadership as an educative process, linking current activities to the larger picture and transformative goals (Foster, 1989). Foster saw that it was necessary to have a view of the potential, the possibilities for change. He advocated that this vision of the possible be presented in narratives, life stories that connect the past and the retelling of the possible narratives of the future (1989). Foster sought "to reveal the taken-for-granted features of institutional life and to allow for commentary on the ways and means that the institution either restrains or promotes human agency" (Foster, 1989, p.54). Such commentary was an important part of the educative aspect of leadership as described by Foster.

These leaders identified the importance of educative leadership in their discussions of role modeling and advocacy. For several of these leaders, leadership and education were reciprocal processes. While Foster believed that leadership was, at its heart, an educative process, Mark and John saw also that *education* was a *leadership* process. Mark's story of his advocacy for and nurturing of his musical student who had been "written off" by other faculty was, as he described, "leadership at an n of 1". John challenged nursing education to provide the leadership for diversity that it currently lacked, with its white face and conforming approaches to difference.

Perhaps the most powerful finding of the study with respect to educative leadership was the drive of these leaders to seek and create opportunities, both for themselves, but more significantly for others. Their willingness to seek challenges, to say "yes" and to take risks in order to transform the profession demonstrated the commitment to the strategic development of the profession that Foster advocated. This finding supported my own leadership experiences where success occurred in the face of willingness to take risks and move in to uncharted territory. However, my own experiences also echoed those of Mark and John in finding a frustrating reluctance and fear on the part of colleagues to chart new waters and move forward confidently into the

unknown. My own experience mirrored the literature that found that nurses generally support the status quo (Falk-Raphael, 2005).

An important aspect of the educative process of leadership as outlined by Foster was a strategic approach to change. Mariam's description of her "chess game" approach in enlisting support for her proposal for cultural competency training in her institution was an example of strategic action. Foster would view her strategic approaches (identifying the impact of the initiative on the external community when dealing with the Chief Executive Officer; discussing the benefits to scopes of practice when dealing with the Chief Nursing Officer; identifying potential financial benefits when addressing the Chief Financial Officer) as educative leadership (Foster, 1989).

Yet another important aspect of educative leadership was the necessity for engagement. Leadership as an educative process could not proceed without "...a complete sense of fulfillment and meaningfulness" (Barendsen & Gardner, 2007). Mark challenged leaders to be "fully engaged in the moment." He spoke of investing "...your life force, your energy, your creativity, and...bringing that to bear fully and wholeheartedly" Leadership, for Mark, was about presence. The educative aspects of leadership were dependent on such engagement.

While these leaders had much to say about how they educated others through advocacy, engagement, strategy and creation of opportunities, they spoke little of how they themselves were educated as leaders. They all spoke of the lessons learned from role models. Some (John, Mariam) spoke fleetingly of literature referenced or research done. Mark was the only one who spoke about research which he had read, or had conducted, with respect to diversity and leadership. Perhaps this relates to the findings of researchers such as Estabrooks and others who found that the most common sources of practice knowledge for nurses were informal social interaction, personal experience, and past practice. (Altug Ozzsoy & Ardahan, 2008; Estabrooks et al., 2005; Estabrooks, Chong, Brigidear, & Profetto-McGrath, 2005; Spenceley et al., 2008). For nurses in clinical practice, knowledge was most commonly acquired socially through interactive communities of practice, rather than in formal reading of research literature. How nurse leaders acquire leadership knowledge is perhaps a suitable question for future research.

### *Leadership as Ethics*

These leaders were moved to lead as a morally purposeful action. As Mariam indicated, “To me, when I see something that needs to be fixed, I have to do something about it or I can’t live with myself.” Leadership was a moral imperative. Their commitment was in many ways a spiritual one. As Campbell noted “Spirituality is viewed as a holistic connectedness of self, others and context, with its interconnectedness as its epitome” (2007, 143). While Mariam’s spirituality was overt, a direct result of her Christian beliefs, others also described leadership in spiritual terms. Both John and Mark spoke of their learning in their experiences with Aboriginal people in deeply emotional, spiritual terms.

As noted earlier, part of the transformative aspect of leadership was that of vision. That vision was a moral one, one based in social justice and a desire to make things better in some way. All of these leaders recognized the morality in what they were doing. They proceeded, directed by a moral compass. However, for some of them, the journey was not easy. Many of them exhibited signs of moral distress (Mark, John, Mariam). Brown and Gillespie (1999) defined moral distress as occurring when organizational and personal barriers “keep us from realizing our deepest moral commitments” (p. 36). Their moral distress was summed up best by Mark: “Can’t we do better than this?”

Despite this moral angst, most of the leaders in this study approached issues with optimism. Many of the leaders in this study, while filled with frustration over the current state of the profession with respect to difference and inclusion, continued to believe in the possibility of influencing developments. Gardner spoke of successful leaders as being

...far removed from the fatalistic end of the scale. They have a powerful conviction that they can affect events in some measure. Leaders at every level must help their people keep that belief. There are too many factors that diminish it. (2003, p.86)

All of these leaders believed that they could influence events. They all approached their cause with passion and vision. While many were filled with dissatisfaction about the current state of the profession, only one—John—seemed in danger of losing this conviction (“I’m getting tired. Getting tired”).

This positive approach to leadership was synonymous with the approaches of authentic leadership outlined in Chapter Two. The origins of authentic leadership lay in the positive tradition that focused on the “best of the human tradition” (Ilies et al., 2005, p. 374). This was highly reflective of Madonna and Katherine and their optimistic views of the world.

Authentic leadership was ultimately directed at the establishment of positive relationships (Ilies et al., 2005). Authentic leadership relied on the character of the leader in the establishment of these positive relationships (Campbell, 2007). Authentic leadership focused on positive role modeling as the major mechanism by which leaders establish relationships and impact followers. This was an approach largely articulated by Katherine and Madonna.

The literature described authentic leadership as relational and moral, but largely introspective. Madonna, while having an awareness of the social structures and mechanisms of control that limit inclusion, focused largely on relational ways of addressing the issues, rather than major policy or managerial approaches. Authentic leadership focused on internal harmony and positive relationships within organizations, a focus which was in accord with Madonna’s approach.

Mariam’s view of leadership was driven by her Christian beliefs. It built on the positive view of human nature present in authentic leadership approaches, but took the concept one step further. She, like Greenleaf (1991), the articulator of the concept of servant leadership, viewed leadership as service to followers. Like Greenleaf, she believed that the true test of leadership was whether it fostered growth in those it served. She saw her job as “managing the peripheries” so that her colleagues could grow and work toward the overall vision of the organization.

As noted in Chapter One, I am, by nature, a positive person. I am also optimistic about the future of inclusion in nursing, despite the significant obstacles. Like Mariam, if I see something wrong, I am driven to change it. Such is my moral relationship with the opportunities posed by inclusion in the nursing profession.

### ***Leadership as Inclusion***

Ryan (2003; 2006a; 2006b) espoused leadership that had inclusion as a goal, and was inclusive in process. His aim was “meaningful inclusion in institutional practices and processes” (2006b, p.5). It was meaningful participation as a black woman in a respected profession that Madonna sought. It was meaningful participation that John promoted when he mentored the young black orderly on his unit. It was meaningful participation that Mark sought for his musical protégé nursing student. It was meaningful participation in the profession and the workforce that Katherine sought for her Aboriginal and immigrant nursing students.

Several of the leaders in this study espoused inclusive leadership styles. Mark’s unwillingness to move on with an important project because of the exhaustion of the faculty, and Katherine’s open door policy and practice of involving staff in decision making, at times to her detriment, were examples of inclusive processes of leadership.

Adding leadership as inclusion to Foster’s previously existing framework was a positive step in developing the conceptual framework of critical leadership. It added a dimension in an area where Foster had previously remained silent. It privileged the importance of inclusion as a basic goal of critical leadership *in general*, not just with respect to issues of diversity. When inclusion was added to critique, transformation, education and ethics as an essential aspect of critical leadership, it became visible on every agenda and in every agenda item. Inclusive behavior, policies and processes became an expectation. As Katherine said, “It’s not an add-on. It’s the norm.”

### ***“So What” About Professional Closure?***

This study explored the concept of professional closure, the controls placed by a profession to limit access and maintain the status of the profession (Dressler, 1994). Several findings of this study related to the issue of professional closure. Katherine’s metaphor of nursing as a cocoon described not only nursing’s eschewing of politics, but also its protection of itself from its surrounding social context, including the increasing diversity in society.

Madonna recognized that success in nursing provided an improvement to her life circumstances. She looked to nursing as a way to gain acceptance and status as a black

woman in Canadian society. She sought what Kirkham and Anderson (2002) meant by *parity of participation*, whereby "...all (adult) members of society... interact with one another as peers" (p. 327). She experienced challenges in gaining access to the profession, both in gaining admission to nursing education because of her foreign education credentials, and also in participating equally in the profession because of her experience with the professor who required her to repeat a course, even though such requirements were not placed on white students in similar situations in the program. Das Gupta indicated that such experiences were common for people of difference in the nursing profession (Das Gupta, 2009).

Hugman's (1991) concept of the creation of sub-groups or stratification as a process of professional closure, as discussed in Chapter Two, was born out in John and Mark's comments about the streaming of Aboriginal students in to licensed practical nursing programs, the lack of support for bridging programs for practical nurses bridging in to baccalaureate nursing programs, and the lack of support for advanced education for Aboriginal nurses. These experiences also support Glazer's conceptualization of segmentation in the profession. Segmentation referred to the "...hierarchically ranked labor markets across which there is virtually no worker mobility; these markets differ from each other in wage levels and benefits, steadiness of employment, job autonomy, and other conditions of employment" (1991, p.352). John and Mark both commented on the impact on underrepresented groups of increasing the entry to practice requirements to the level of the baccalaureate degree. This view was also reported in the literature (Rheume 2003).

I have witnessed professional closure in my own practice. I have seen the attempt to segment and stratify the nursing workforce as described by Hugman (1991) and Glazer (1991) in the resistance of my university-based colleagues to creating bridging opportunities for practical nurses into university baccalaureate programs. This resistance is often expressed in dismissive and punitive ways. I have heard opinions expressed by university-based academics that imply that there is actually a need to "undo" the previous "inferior" education that practical nurses bring to academe. I have seen this disdainful approach to previous learning, both formal learning through education programs based in

technical institutes and community colleges, and prior learning gained in work experience, reflected in other professional programs, such as engineering and accounting.

Yet another mechanism of professional closure that I have witnessed in my own practice is the reliance on high school grades for admission to baccalaureate nursing programs. I have seen this as an issue with respect to Aboriginal students. High school marks privilege those students who can successfully demonstrate westernized ways of knowing as measured in high school performance, but fail to recognize other skills and abilities brought to a professions by Aboriginal and other minority group students. This overreliance on high school grades can be mitigated through the use of affirmative action programs such as those advocated by Mark, wherein seats are reserved for students of minorities who meet the minimum requirements of the program. This ensures a basic skill set in the minority student group which will allow them to be successful in the program but does not require them to compete with students who were exposed to westernized approaches to teaching and learning from birth. However, such actions only serve to minimize the negative effects of standardized high school requirements. They do not serve in any way to honor and acknowledge the particular competencies that Aboriginal and other minority group students bring to the educational setting.

I recently experienced the potential for professional closure when I took part in a national exercise directed at establishing English language benchmarking for internationally educated nurses (IENs). The Canadian nursing profession had agreed, through its national organizations, to establish one common language test for IENs as a way to standardize and simplify requirements. Interestingly, while there were nurses present at this exercise who would definitely have preferred to set standards of English language proficiency so high that most nurses, native or internationally born, could not meet them, there was a genuine desire on the part of most present to balance fairness and reason in establishing common language requirements for IENs, with requirements for the protection of the public. From my own perspective, this situation was another example of the challenges of using standardized tests, such as language tests, alone in determining the potential for success of IENs, and the importance of providing language and cultural interpretation and support as part of ongoing support programs for IENs.

### ***Conclusion: So What?***

So what are the chief findings of this study, and how are they relevant? This study explored the experiences of five significant nurse leaders, and provided a window on their experiences, how they responded to these experiences, and how the experiences were made sense of in the stories they shared. This study revealed in stories of the experiences of these leaders the complexities, trials and triumphs of those who are trying to make a diversity difference in the nursing profession. The findings and their relevance may be summarized as follows, as pertains to these leaders:

- The leaders in this study who successfully championed diversity in nursing did so from perspectives of fairness, function, and parity of participation.
- Many of these leaders had personal experiences of being excluded because of their individual difference, and these experiences informed their approaches toward difference in the profession.
- Many of these leaders were exposed first-hand to the exclusion of others from the profession and from the mainstream of society, and were personally and emotionally affected by these experiences.
- Many of these leaders advocated the creation of “safety zones” where people of difference can safely reflect and dialogue about their understandings.
- Many of these leaders identified the importance of role models and mentors for people of difference in helping them succeed in the profession.
- Leadership for these leaders was critical, transformative, educative, ethical and inclusive.
- Critical leadership was for these leaders a process of critique, dialogue and reflection.
- Critical leadership was about power.
- Critical leadership was about conflict.
- Critical leadership was about humor.



- Critical leadership was about expertise.
- Leadership was a transformative process, leading at the least to a different, more socially just nursing profession.
- Transformative leadership was about passion.
- Transformative leadership was about vision.
- Leadership, to be successful, must be an educative process.
- Educative leadership was about creating and recognizing opportunities.
- Educative leadership was about advocacy.
- Educative leadership was about engagement.
- Educative leadership was about strategy.
- Leadership was an inherently ethical process.
- Ethical leadership was about authenticity.
- Ethical leadership was about humility.
- Leadership was about inclusion.
- Inclusive leadership was both a goal and a process.
- Leadership for inclusion was about eliminating processes, structures and attitudes that prevent the inclusion of people of difference in the profession of nursing.

In summary, the study findings supported a broad view of diversity, transcending culture and ethnicity to include different ways of thinking and being. The findings supported further exploration of inclusive approaches to difference in the broadest sense.

The findings of this study with respect to leadership supported and elaborated upon Foster's 1986 and 1989 views of leadership as critique, transformation, education and ethics, and supported the addition of an additional dimension that of inclusion, based on the work of Ryan (2003; 2006a; 2006b).

These findings about diversity and leadership, and about leadership for diversity, may be used to challenge the nursing profession to look beyond its current day-to-day tasks, and to move beyond its current locked-down, controlled, risk-averse practices, to embrace the possibilities of the profession's role in building a better, stronger, and more inclusive profession, and a better, stronger, more just society.

### ***Conceptual Framework Revisited***

The conceptual framework for this study was described in Chapter Two. The study grew out of the profession of nursing's contract to meet the needs of society, with specific reference to social justice. The social justice focus of this study addressed diversity and inclusion in the profession. The study looked at the effects of professional closure in limiting the participation of marginalized groups within the profession, and proposed that critical leadership approaches including critique, transformation, education, ethics and inclusion would act on the profession to reduce the effects of professional closure and increase inclusion in the profession.

The study expanded the conceptualization of diversity, beyond the nurse scholars' traditional narrow views of culture, ethnicity and race. It revealed a conceptualization of diversity in relation not only to characteristics, but also to thoughts, and exposed a "locked down" approach toward acknowledging difference in the profession. Participants in the study emphasized the importance of addressing the fear and tension that arose when diversity increased in the workplace, and the importance of safe places, physical and emotional, wherein members of marginalized groups can explore their experiences. The study illustrated the importance of role models in supporting marginalized people in the profession, and demonstrated the need for active solutions to address exclusion in the profession.

The study findings revealed the existence of professional closure within the profession, and pointed in directions for further development of this concept in relation to the nursing profession.

The study expanded the conceptualization of critical leadership, further developing and expanding the conceptual framework initially proposed. The expanded framework outlining the conceptualization of critical leadership which arose from the study is included in Figure 5.1.

The stories of the nurse leaders in this study embodied all of Foster's aspects of critical leadership: critique, transformation, education and ethics. The stories of leadership also supported the addition to the conceptualization of leadership Ryan's view of leadership as an inclusive practice (2006).

Leadership as critique involved reflection on the power relationships existing in the leader's social and political environment, and in an analysis of the conflict that arose as a result of the power dynamics. Critical leadership involved reflection regarding the expertise that the leader brought to bear on the environment. For most of these leaders, critical reflection also involved a healthy dose of humor as a way of maintaining perspective and building relationships in the environment.

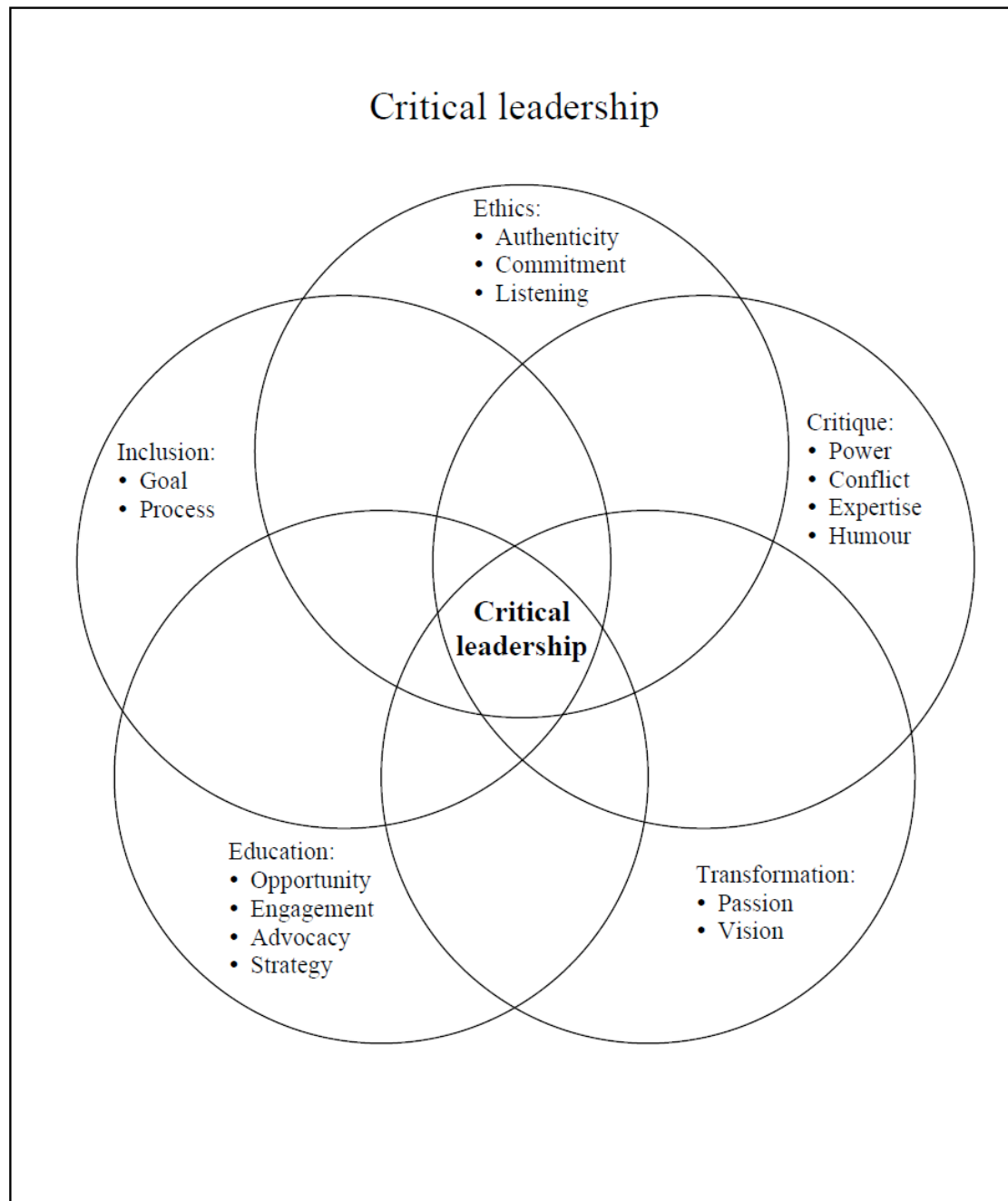
A clear vision of what could be, and a passion and angst that drove the leader to accomplish that vision, were aspects of transformative leadership found in the study participants. Transformative leaders were positive and moved their issues steadily forward.

Leadership as education required active engagement in change, a strategic approach to accomplishing leadership goals, and a strong mentorship/advocacy role. Above all, educative leadership entailed being open to possibilities, and to recognizing and creating opportunities to achieve the leadership vision.

Authentic relationships, based on honesty and respect were the basis of ethical leadership. Ethical leadership did not occur without careful listening, and a commitment to those involved.

Leadership for inclusion inspired inclusion as a goal, but also required leaders to look at inclusive processes in visioning and decision-making.

Figure 5.1 demonstrates the interlocking relationship between the five facets of critical leadership, with critical leadership occurring at the center, where all of the facets overlap. Based on the experiences and narratives of the nurse leaders in this study, critical leadership involved all five aspects of leadership: critique, transformation, education, ethics, and inclusion. Critical leadership, including all of these facets, assisted these nurse leaders in breaking down barriers to inclusion and opening the profession to increased diversity, thereby assisting the profession to meet the requirements placed on it by the profession's contract with society to reflect the population it serves and to meet that population's needs.



*Figure 5.1* **Critical Leadership**

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### **Implications of the Study: Now What?**

To this point this dissertation has focused on the “What?” and the “So what?” of the study. At this point it is necessary to look at the “Now what?” What were the implications of this work? This section of the chapter looks at the implications of the study with respect to theory, practice, research, and policy.

Kirkham and Anderson (2002) warned against attempting to draw conclusions from the data of interpretive studies, advocating tentativeness in interpretations. Thorne and Darbyshire (2005) also warned of folly at the other end of the scale, that of attempting to let the data “speak for themselves,” failing to draw any analysis from the data. Thorne and Darbyshire, with tongues firmly planted in cheeks, warn against aims of “cardiac” and “lachrymal” impact – invoking heartfelt and tear jerk reactions. Was it reasonable then to expect conclusions from a qualitative narrative study such as this one?

“Individual action and biography must be the starting point for analysis, not the end” according to Riessman (1993, p.70). As such, it was my intent that the personal stories of inclusive leaders in nursing, viewed and analyzed through a political lens, identified themes that could be further researched and developed in both qualitative and quantitative methodologies. The identification of these themes had the ultimate purpose of enhancing theory, practice and policy with respect to diversity in nursing, and other professions as well. I intended that this study would provide a richness and thickness of data that is currently absent in the field, and serve as a jumping off point for a program of research that would support and direct policy development to enhance inclusion within health professions and professions in general. The following portion of the chapter discusses the implications of the study with respect to theory, practice, and research and policy development.

#### ***Implications for Theory***

This study addressed and developed the concepts of diversity, critical leadership and professional closure in relation to nursing. The conceptual framework of the study was based on the contract that the profession has with society to meet societal needs. The study findings posed questions about the relationship of the nursing profession to society, specifically in relation to the way in which the profession addresses issues of social

justice. The study findings suggested a need for the profession to reexamine its history and its relationship with society with respect to its role in creating a just society.

The specific social justice focus of this study was on diversity and inclusion in the nursing profession. Much of the previous theoretical work around diversity and nursing was related to the diversity of clients, and not to diversity within the profession itself. When the nursing literature addressed difference, it was generally done with respect to culture, ethnicity and race. Research on barriers to minority participation generally viewed lack of participation as accidental, based on individual choices. This study looked at barriers to inclusion through historical, political and social lenses. The findings of this study contribute to the understanding of diversity and inclusion in nursing by situating the conceptualization of difference beyond culture, ethnicity and race, in the broader context of diversity including differences such as gender, sexual orientation and ability--physical, emotional and intellectual. More importantly, the study tackled difference in the profession at its most basic level, the level of *diversity of thought*, and exposed an overwhelming pressure for conformity and “locked-down thinking” within the profession.

The findings of this study pointed to a need for exploration and development of the theoretical understandings of how such conformist processes occurred in professionalization. Is conformist thinking really the prevailing view in the nursing profession? If so, why? Are nurses by nature conservative thinkers? Is such “locked-down thinking” a natural response to the overwhelming life and death demands inherent in modern nursing practice? Or is this process actively cultivated by the profession as a safety mechanism in response to these demands? Can nurses respond to the acute demands of daily nursing life (“the murky mire of the minute”, in John’s words), and also maintain a view of the horizon with the intent of engaging in alternate ways of thinking, doing and being? In the process of developing as a profession, how has nursing balanced its need for precision and standardization of responses in crisis situations with the need to envision and act on broader perspectives and to entertain such bold choices as those proposed by such leaders as those who participated in this study? The findings of this

study supported further investigation at a theoretical level of these contradictory directions in nursing practice.

Professional closure as a theoretical construct was also addressed in this study. Participants in this study supported the views espoused in the literature that professional closure was at work in the nursing profession. The findings in this study raised further questions. To what extent did the profession, in its desire to increase its status in the male physician-dominated world of health care, limit access to the profession by marginalized groups? Was this an inadvertent result of attempts to increase status through professionalization, or was there something more sinister at work here? The study findings suggest that the concept of professional closure requires further theoretical development as it applies to the nursing profession.

This study incorporated the concepts of critical leadership found in Foster's work (1986; 1989) and augmented by Ryan (2006a; 2006b) into a conceptual framework for critical leadership that was further developed in specific relation to nursing leadership. Injecting this conceptual framework for critical leadership into the theoretical discussion of nursing leadership has the potential to expand the limited managerial and technical approaches to nursing leadership currently found in the literature. The critical conceptual approaches to leadership of this study have significant application and appropriateness in expanding our understanding of nursing leadership in general, and in relation to diversity and inclusion, specifically.

### ***Implications for Practice***

The study findings have implications for the nursing profession, for nursing education and nursing practice in general, and for nursing leaders in specific. The findings suggest that the profession needs to look critically at its perspectives on difference and inclusion, and examine how the profession creates barriers to participation. The review of the literature and the experience of the study participants revealed many barriers. Mark admonished the profession to give up its "mix and stir" approaches to difference. John challenged the profession to open itself to diversity, specifically to diversity of thought. Studies such as this challenge the profession to have the difficult discussions around racism, prejudice and discrimination within the profession and in its

practice settings. The stories of these leaders imply a need for the profession of nursing, individually and through its professional groups and institutions, to engage in reflective, critical dialogue with people who have traditionally been discouraged from entering the profession, and with people of difference within the profession, in order to understand their narratives in truly meaningful ways. Nurses individually and through their professional organizations are dared by these stories to engage in the difficult conversations around issues of racism, prejudice and exclusionary behavior, and how they play out in day-to-day nursing life.

The stories of these leaders pointed out the need for nurses as individuals and through their professional groupings to be challenged to address their culture of conformity and sameness-- the resistance to diversity of thought that limits the profession's ability to grow and respond to its community. The findings challenged the profession to leave its cocoon for the purposes of true and meaningful dialogue and reflection with the public it serves.

A re-visioning of nursing leadership beyond the technical, managerial approaches that predominate in the literature was suggested by the stories of these leaders. The study findings suggested a model of leadership that linked the current, inward focused habits of the profession with the transformative vision of a brave new world based on inclusion and social justice. It challenged the profession and its leaders to engage the possibilities of transformative change.

Arising from the study findings is the suggested need for a collaborative discussion of the roles of both leaders and frontline staff in developing and living a shared vision of the institutions where nursing is practiced, their missions, and their relationship to society at large.

One of the most significant implications of this research is the lesson it provides to nursing and to other professions to be open to the research and literature of other professions in transforming their own work. The nursing literature was powerfully supplemented and given meaningful direction by the well developed work on leadership for social justice and transformative leadership found in education. Nursing practitioners and researchers alike have much to learn from a broad, inclusive approach to scholarship



about the profession, rather than restricting their reading to writings in the field of nursing alone.

### ***Implications for Research***

This study was an inductive exploratory study, addressing an area where virtually no research existed in the past—that of critical leadership for diversity and inclusion in the nursing profession. This study could form the basis for much larger studies involving nursing and other health professional leaders in several different English-speaking countries, using mixed methods approaches, including survey data and semi-structured interviews. Such studies would serve to further develop and test the critical leadership conceptualization generated by this study. Critical leadership could be further studied in relation to diversity and inclusion in the profession, but could also be explored in relation to nursing leadership in general. A general exploration of critical leadership in nursing would add to the literature in the area of “big picture” approaches to nursing leadership, to expand the managerial focus of much of the current nursing literature.

Nursing leadership in relation to each of the leadership concepts-- critique, transformation, education, ethics, and inclusion--should be further explored, using this study as a basis of enquiry. Each of the sub-concepts with respect to leadership (conflict, humor, passion, vision, etc.) can be further studied, and their meanings deepened and widened with respect to nursing leadership. In particular, this study suggested a need for more research in the area of nursing leadership and conflict; nursing leadership and moral distress; nursing leadership, conformity and diversity of thought; nursing leadership for social justice, and nursing leadership and humor. In addition, the findings of the study implied a need for further investigation of how nurse leaders gain leadership knowledge. Qualitative methods, including narrative inquiry, would provide a richness of storied data to further understandings in these areas.

With respect to diversity and difference, this study suggested a need to further develop an understanding of how nurses and nurse leaders define difference. The nuances of the approaches of fairness, function, and parity of participation in increasing diversity in nursing need to be further explored, using this study as a basis for that exploration. This study showed that many of the leaders involved came to their interest in difference

because of their own experiences of difference. The finding in this study that personal experience of being different produced a different approach to leadership needs to be further studied. Comparative studies of leadership as experienced and demonstrated by leaders from backgrounds of difference and leaders representing mainstream society are suggested. Further exploration of the comparative importance of expertise and confidence in the success of nurses and nurse leaders from diverse and mainstream backgrounds is also suggested.

John and Katherine both made points about the dichotomy between nursing leaders and front line nurses and nurse educators with respect to envisioning the future of the profession. This deserves further study. What are the current and potential understandings in the profession, at leadership and frontline levels, with respect to the importance of vision, and the importance of shared vision? How can such shared vision be created? How does vision differ between leaders and frontline nurses? What are the current roles of leaders and frontline staff with respect to shared vision? What might they be?

This study raised many questions with respect to professional closure. The experiences of these leaders indicated that professional closure was a factor in nursing. Most of these leaders reported experiences with professional closure personally, and indicated that it was a factor for students and colleagues as well. More research could further develop a picture of professional closure in nursing, based on broader evidence.

During the research process for this study, one of my committee members suggested that these leaders should be brought together to dialogue on the issues addressed here. The synergy and dynamism of such a dialogue would inform the learning immensely. Unfortunately time did not allow for such a process as part of the dissertation. Developing a proposal for such a process and seeking funding from organizations such as the Canadian Nurses Association, the Aboriginal Nurses Association of Canada and the Canadian Association of Schools of Nursing is the first thing on my research agenda after completing this dissertation process.

There are also methodological implications of this research. In doing narrative inquiry research myself in the future, and in making recommendations to other narrative

researchers, I would suggest alternate methods of data analysis to Labov's structural and Mischler's functional analyses of narratives, which produced rather limited, mechanistic results. The analytic frameworks of Clandinin and Connelly (2000) or Chase (2005) would offer broader, more interpretive frameworks for analysis in the future.

Another methodological consideration for future narrative research that arose from this study involved the way in which the narratives were constructed. The stories of the individuals in this study were interspersed with researcher analysis, interpretation and commentary—the use of the *authoritative* voice, according to Chase (2005). Consideration could be given in future studies to privileging the voices of the participants alone and letting the power of their stories speak for itself—the use of Chase's *supportive* voice (2005). In doing this, the results might be more fluid, with the researcher's voice less interpretive and intrusive in the story-telling process.

If narrative research is to be conducted on this topic in the future, it will be necessary to resolve the issue of the appropriateness of the use of telephone interviews for such research. While historically it was assumed that in-person interviews produced stronger relationships between researcher and participant, which in turn strengthened the research, there is current thinking that suggests that telephone interviews allow the participant more control and comfort, and that such interviews privilege the stories themselves, rather than allowing the story-telling to be derailed by artifacts and environmental considerations present in in-person interviews (Holt, 2010). Future research needs to further explore this methodological issue.

This research provides many potential opportunities for my own research program in the future, but also provides a basis for researchers in nursing and other disciplines to further develop and define the concepts of diversity, critical leadership and professional closure. There is opportunity to involve researchers from other health sciences disciplines, and from other non health-related professions, particularly education, in comparative studies addressing similarities and differences between professional groups with respect to the major themes of the study.

### ***Implications for Policy***

The study findings informed a number of potential policy initiatives. They suggested the need for a national level policy discussion around inclusion and difference, bringing together leaders from a variety of sectors, such as the Canadian Nurses Association, Canadian Association of Schools of Nursing, Aboriginal Nurses Association of Canada, Association of Canadian Executive Nurses, and the Canadian Federation of Nurses Unions, with an expectation that national, participant-endorsed policy directions would emerge as a result of such discussions. Study findings suggested the need for national level discussions between nursing organizations, other health professional organizations, and health care provider agencies around a formal, national commitment to increasing the diversity of the health professions and health workforce, and to the development of policy to ensure positive actions that would facilitate and monitor this development.

The need arose from the findings of the study for national level commitment of educational institutions to the creation of diversity committees and diversity offices in each educational institution such as those in Katherine's institution, with the supportive policies that allow leaders to promote diversity and deal quickly and effectively with incidents of racism and prejudice.

This work suggested the need for national level policy development ensuring compulsory cultural safety programs as part of general orientation programs in health care institutions. These programs would be aimed at ensuring positive experiences for both patients and staff from marginalized backgrounds.

The study findings raise the potential for national nursing organizations to jointly create and support an Academy for Critical Leadership in Nursing, with a focus on creating and supporting a critical, transformative approach to the role of nursing in society in general, and with specific attention to issues of inclusion.

Study findings suggested the need for the Canadian Association of Schools of Nursing to host a round table discussion of its member schools to address the imperative of increasing diversity and inclusion in nursing education and address the implications of immediately adopting the core competencies outlined in the recent document *Cultural*

*competence and cultural safety in nursing education* in nursing curricula as a required part of national accreditation standards (ANAC/CASN/CNA, 2009).

The importance is suggested for increased cross-cultural experiences for students in nursing education. Such experiences would be intended to create positive experiences with groups previously unfamiliar to students, with the purpose of decreasing Othering and creating inclusionary communities of difference as proposed by Shields (2004a).

Findings also demonstrated the need for dialogue and policy development regarding active or affirmative actions with respect to national targets for admission of underrepresented minorities in nursing education, the need for bridging programs for practical nurses to access baccalaureate education, and the need for policies around the implementation of programs promoting fast-tracking of minority students through baccalaureate education to master's and PhD preparation, with an ultimate aim of increasing the diversity of the professoriate.

The study suggested the need for policy development related to English language requirements for internationally educated nurses that are evidence based, nationally standardized, and that balance the desire to increase inclusion in the profession with client safety.

Findings suggested the need for the collection of national statistics in the profession, in education and in practice with respect to minority participation in the profession. This data should include attrition statistics and exit interview information on the experiences of minority students and nurses in practice, such as that suggested by Mark in his narrative.

The study suggested the need for the profession to develop policy to counteract the inadvertent negative impact on minority students of moving to a degree as the entry credential for the profession, and mechanisms to reduce these negative results, such as increased financial aid for students from targeted recruitment groups.

The stories of these leaders also implied the need for these discussions to be far reaching, suggesting the possibility of expanding these policy initiatives beyond national borders through involvement with nursing organizations such as the International Council of Nurses and the Global Alliance for Nursing Education and Science.

### **Conclusion**

This section of the chapter addressed the implications of this study with respect to theory, practice, research, and policy development. This study informed our knowledge about leadership for diversity and inclusion in the nursing profession through the stories of five passionate, committed, and visionary leaders in the profession. Their stories gave life and meaning, through the articulation of their passion, values and ideals, to the previously disembodied concepts of justice, inclusion, leadership and professional closure. They shared their stories generously and authentically with a goal that we might understand diversity, inclusion and leadership better and, hopefully, be inspired to do better. Any failure to accomplish this goal is wholly the responsibility of the researcher. The leaders gave it their all.

### **Reflections of the Researcher Regarding the Study**

This study arose out of my own personal experiences and frustration with the current state of diversity and inclusion within the nursing profession. As an administrator I have been involved in policy and program development which has supported the participation of Aboriginal people in nursing education for over 15 years. I am very proud of the successes of the Aboriginal students who have graduated from the Nursing Education Program of Saskatchewan, the program in which I have taught and been an administrator since 1996. The Nursing Education Program of Saskatchewan is known to have the highest number of Aboriginal students of any nursing education program in the country (Gregory, 2007). Despite our students' successes, I do not rest easy with respect to the experiences of Aboriginal and other minority students in nursing education, and I fret about their experiences in practice.

My original intent in doing this dissertation was to look at policy initiatives to support inclusion in nursing education and practice. However, I became increasingly uncomfortable with the staid and static nature of such discussions. I wanted to understand on a meaningful personal level the implications of such policy initiatives. I wanted to enter the dialogue about difference within the profession. I also wanted to understand better how good things could be made to happen in this area in the profession. How could success be supported, nurtured, and celebrated? How could lack of success be reflected

upon, dissected, and embraced as an important part of the learning and evolution of the profession? My discussions with my dissertation supervisor, Dr. Keith Walker, slowly moved me away from a narrow policy focus to an interest in the stories of people who had made inclusion happen in the profession. This gave needed life and flavor to my work and focus.

I had always been interested in the two lives of leaders: the externally focused life of the leader which requires vision and a clear sense of the mission of the organization and the leader's role within it; and the life internal to the organization, which requires interprofessional skills, negotiation skills, conflict management skills and an ability to share and co-develop the external vision in a way that is meaningful to and supportable by those within the organization who manage the front line.

In Foster, I found someone who addressed both of these lives, and brought them together in an approach that resonated with me in a highly personal way. His view of leadership as critical and transformative spoke to the need for passion and vision and a clear understanding of how my leadership in my profession related to my personal goals of democracy and social justice. His view of leadership as educative and ethical inspired me to build relationships with colleagues that require respectful, authentic ways of relating, as well as reflective dialogue focused at developing shared understanding. The addition of Ryan's views on inclusion rounded out my own personal views of leadership as an inclusive process, a process that also had inclusion as its goal.

While I was excited by Foster's work and the reading and thinking that this study incited, it was not until my first interview with Mark in August, 2009 that I had some sense of the true possibilities that such an inquiry could create. At the end of the interview, I sat and reflected not only on the remarkable content that Mark had given me, fodder for years of reflection and dialogue; I thought also of the process we had just shared. In the space of two hours this person had shared with me his vulnerability, his successes, his failures and his challenges as a leader dedicated to increasing inclusion in the nursing profession. He had shared so openly and so authentically, at some personal risk to his privacy and his public image, for no other reason than his deep abiding passion for his profession, and his commitment to inclusion in the profession and in society of

those who are currently seen as different. I thought, “Wow, we are really on to something here”. And I was right. The profound experience of that interview was repeated 11 more times throughout the next six weeks, as all of these nursing leaders gave so generously of themselves to this process. At the end of it all I was left with the thought, “How can I possibly do justice to these people and their stories?” Such a privilege, such an honor, but—so intimidating!

I wrestled with these feelings of trepidation as I constructed the stories of my participants, using their own words to weave their narratives. I became completely engaged with these people as their words and thoughts became more and more familiar to me. I was also very protective of them, wanting to ensure that I was not increasing their vulnerabilities in the way I told their stories. After a month alone in my basement office with these leaders, I came to the uncomfortable place of having to share these people with the world. Not only were their vulnerabilities going to be obvious, but so were mine! My choice of framework, of focus, and of stories told and those left untold—all were now about to be exposed for critique by my readers.

I chose as my first reader my husband of 31 years. Laurie Thompson. This was not necessarily the safest choice. While he has been the most supportive spouse anyone could ask for, and has been with me through some significant challenges during the course of this study, including my breast cancer diagnosis and treatment and the death of my beloved mother, we have very different approaches to research in specific, and life in general. As an economist and political scientist by training, his empirical realist approaches were very different than my own radical humanist perspectives. While overwhelmingly supportive of my studies, he harbored, I knew, some unexpressed reservations about narrative inquiry as a choice of method.

It was with much trepidation that I shared “my people” with him. His response was overwhelming. His first statement to me was, “I want to meet them all”. His engagement with my “people” was clearly revealed when our daughter Beth, a 22 year old first year education student, spent an evening with us, and he recounted to her, with great passion and reverence, the stories of each of the participants. He said to her, “As a future teacher, you have to read these stories. You have to understand the experiences of



people who are seen as different, and, as a professional, you have to know that leadership is needed to change those stories”. At that point I thought, “Okay, maybe I came close to doing these folks justice”.

Recently my good friend and colleague Donna Brunskill, Executive Director of the Saskatchewan Registered Nurses Association for the last eight years, retired. Donna is a truly critical, transformative, educative, ethical and inclusive nursing leader. At her retirement celebration, she told a story about another transformative Canadian nursing leader, Ginette Lemire Rodgers, who once gave her some advice when Donna was experiencing criticism for some recent policy decision. Ginette said, in her wonderful French Canadian-accented English, “Donna, if they aren’t shooting at you, you aren’t leading enough”.

This is one of the important lessons that this study has taught me. These leaders have said clearly that critical leadership is messy. It is not easy to create a shared vision of a just profession and a just world. It is not easy to translate a big picture vision to colleagues who are overwhelmed with the seriousness of their daily tasks. Leadership is not a popularity contest, and people will take shots at you. Leadership requires passion and vision and humor, and much more. But as a leader you move ever forward, guided by your moral compass, your commitment to the profession, and a belief that we can indeed, do better than this.

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## APPENDIX A

### Relationship between Research Problem, Research Questions, and Interview Questions

<b>Research problem:</b> What are the experiences and stories of nurse leaders who have increased diversity and inclusion within the profession through their leadership?	
<b>Research questions</b>	<b>Instrument questions **</b>
How have these nurse leaders come to their current conceptions of leadership, and what are these conceptions?	<ol style="list-style-type: none"> <li>1. Please share with me some stories about your background and your nursing career. Where did you grow up? Where did you study nursing?</li> <li>2. Is there a story around how you came to choose nursing as a career? And what about how you came to be where you are today? Do you believe that there are overarching values or purposes expressed in these stories that contribute to where you are today?</li> <li>3. How do you see leadership? What does it mean to you? Can you share with me a story that illustrates this?</li> <li>4. Can you share some stories of the leaders that have influenced your life? What made them effective, or ineffective?</li> <li>5. What is the story behind how you came to be a leader in nursing? In general? In relationship to diversity and inclusion?</li> <li>6. Are there some basic beliefs and values that sustain you as a leader? What are they?</li> </ol>
How have these nurse leaders come to their current conceptions of diversity and inclusion, and what are these conceptions?	<ol style="list-style-type: none"> <li>1. My research is about leadership in relation to diversity and inclusion in nursing. From your experience, could you comment on how you see diversity and inclusion? What do the terms diversity and inclusion mean to you personally? Are there stories you could share with me about these views?</li> <li>2. You are known as a nurse who is committed to promoting diversity and inclusion in nursing. How do you think others have come to see you in this way?</li> <li>3. How did you come to be interested in diversity and inclusion? Are there any life experiences and stories that have inspired your commitment to diversity and inclusion?</li> </ol>

	<ol style="list-style-type: none"> <li>4. Can you share some of your experiences with diversity and inclusion? In general? In nursing particularly?</li> <li>5. Are there some basic beliefs and values which sustain your interest in diversity and inclusion? How did you come to these beliefs and values?</li> <li>6. Are there any personal or professional relationships that have particularly sparked your interest in diversity and inclusion? Can you share the stories of these relationships?</li> <li>7. If you were addressing a group of nursing leaders, what would you say to them regarding diversity and inclusion in the profession?</li> <li>8. Are there any life experiences and stories that have particularly sparked your interest in leadership?</li> <li>9. How do you see your role in providing leadership? In general? In relation to diversity and inclusion? In relation to diversity and inclusion in nursing?</li> <li>10. If you were addressing a group of nursing leaders, what would you say to them regarding leadership in the profession?</li> </ol>
<p>How might the range and variety of experiences and stories of nurse leaders be described with respect to leadership for diversity and inclusion within the profession and the relevant systems?</p>	<ol style="list-style-type: none"> <li>1. What are your experiences with respect to the commitment of nursing as a profession to diversity and inclusion within the profession itself? Could you tell me stories of your experiences -- at the level of individuals, institutions and the profession itself, as applicable? (Probe with respect to barriers and supports experienced)</li> <li>2. Tell me about some successes, and some less than successful leadership stories, in promoting diversity and inclusion in nursing. What made the difference in these experiences?</li> <li>3. If you were addressing a group of nursing leaders, what would you say to them regarding leadership for diversity and inclusion within the profession?</li> </ol>

\*\* There are additional process related questions included in the interview questions, eliciting comments and concerns arising from the previous interview, clarifying themes



that have arisen, and seeking assistance in identifying and contacting additional participants. The complete interview guide can be found in Appendix B.

## **APPENDIX B**

### **Application for Ethics Approval of Research Protocol**

University of Saskatchewan Behavioral Ethics Board

Submitted to the Behavioral Research Ethics Board

Submitted: January 8, 2009

Revised: March 17, 2009

**RESEARCHER:** Lois Berry, RN, BN, MCEd, PhD(c)  
Department of Educational Administration

**SUPERVISOR:** Dr. Keith Walker  
Department of Educational Administration

<b>DATA COLLECTION</b>	<b>START DATE:</b>	January 30, 2009
	<b>COMPLETION DATE</b>	January 30, 2010

**TITLE OF STUDY:** Making a diversity difference: Stories of leadership creating a more inclusive nursing profession

**ABSTRACT:** This research is intended to help us gain an understanding of leadership that aims to increase diversity in nursing, from the perspective of five individuals who have championed the inclusion of Aboriginal people, visible minorities and immigrants within the profession.

The purpose of this research is to understand how selected nursing leaders have come to see the importance of increasing the diversity of the nursing profession complement, how they have conceptualized diversity and inclusion, how they have attempted to increase inclusion, and how they have fostered increased participation of diverse groups in the profession. This research focuses on their experiences and stories.

The research problem is stated as such: What are the experiences and stories of nurses who have successfully provided leadership to increase diversity and inclusion within the profession?

The research questions include:

1. How have these leaders come to their current conceptions of nursing leadership and what are these conceptions?
2. How have these leaders come to their current conceptions of diversity and inclusion and what are these conceptions?
3. How might the range and variety of experiences and stories of nursing leaders be described, with respect to leadership for diversity and inclusion within the profession and the relevant systems?

The study uses adapted narrative inquiry approaches to elicit and report participant stories. Data will be gathered through semi-structured in-depth interviews, face-to-face when possible, and via telephone.

**FUNDING:** The study is self-funded.

**EXPERTISE:** The participants will be experienced professional nurse leaders from education and practice settings.

**CONFLICT OF INTEREST:** As the participants are leaders in the nursing profession in a variety of roles, and as I have been a nurse for 33 years and a nurse educator for 29 years, I have met some of the proposed study participants previously. I have not had, nor do I currently have, any known formal employment, research or professional organization relationships with any of the prospective participants.

**PARTICIPANTS:** Participants will be identified by the researcher using purposive sampling techniques. The researcher will elicit suggested names of suitable participants from formal nurse leaders, including the past president of the Canadian Nurses

Association, the executive director of the Saskatchewan Registered Nurses Association, and the president of Aboriginal Nurses Association of Canada (ANAC). These leaders will be asked to identify nurses who, in their view, have championed diversity in nursing, and have provided leadership to successfully increase the participation in nursing of members of the following groups: Aboriginals, immigrants and visible minorities. These nursing leaders have been selected to provide names based on their long history with the nursing profession, and their knowledge of nursing issues from a broad perspective. The researcher, by virtue of her history in the profession, knows of some of these individuals as leaders by reputation, and knows of their ability and willingness to provide names of diversity champions in the profession. Two of these leaders are known to the researcher personally. The third is not (president, ANAC).

Participants will be selected in two stages. In the first stage, three participants will be selected from the names suggested by the nurse leaders. The participants will be selected based on their work with one of the target diversity groups. Each nurse leader will be asked to if he or she is willing to forward the letter of invitation (Appendix 1, Letter of Invitation/ Information about the Study/ Consent form) to the potential first stage participant via email. The letter of Invitation will invite the potential participant to contact the researcher via email or telephone to indicate an interest in participating. The email letter requesting assistance from the nurse leader in soliciting participants is included in Appendix 1 (Request for Assistance).

The researcher will then use snowballing techniques to have the initial participants provide names of additional prospective (Stage 2) participants. There will be an attempt to solicit names from jurisdictions outside of Canada for at least one of the participants. Each Stage 1 participant will be asked at the conclusion of the last interview if he or she would be willing to suggest additional participants. Upon agreement, and following discussion between the participant and the researcher with respect to balance and representation, the researcher will forward via email to the Stage 1 participant a copy of the Letter of Invitation/Information about the Study/ Consent form (Appendix 1), and

request that the Stage 1 participant emails the Letter of Invitation to the potential stage 2 participant. The letter of Invitation invites the potential stage 2 participant to contact the researcher via email or telephone to indicate an interest in participating in the study. The email letter requesting assistance from the Stage 1 participants in soliciting stage 2 participants is included in Appendix 1 (Request for Assistance).

The study will involve up to six participants. Participation involves two semi-structured in-depth interviews directed at eliciting stories of leadership in relation to increasing the recruitment, inclusion, and retention of members of the targeted diverse groups in the profession of nursing. Interviews will be a maximum of two hours, and will be either face-to-face or by telephone, depending on the location of the participants. Data will also include any artifacts –pictures, letters, articles—that the participants wish to share, and interviewer’s notes.

**CONSENT:** Written consent for study participation and for audio taping of interviews will be received from all study participants. See Appendix 1 for a copy of the required consent form.

**METHODS/PROCEDURES:** The study is a qualitative one, using adapted narrative inquiry approaches to gather, analyze, and report the data. Data will be collected through two semi-structured, in-depth interviews of a maximum of two hours duration. The two interviews can be integrated to be completed in one session, if this is the preference of the participant. Interviews will occur in a setting of each participant’s choosing, with consideration given to both privacy and anonymity. Interviews will be tailored to the specific interviewee, based on their experiences. As previously noted, data will also include artifacts and interviewer’s notes. See Appendix 3 for interview guide.

**STORAGE OF DATA:** All audio records, computer discs, hard copies of transcripts, and researcher’s notes will be stored in accordance with the University of Saskatchewan

guidelines during the study (Kept in a secured place by the researcher) and after the study (minimum of five years by the advisor, Dr Keith Walker) and will not allow for identification of any persons. All material will be destroyed after the mandated time.

**DISSEMINATION OF RESULTS:** The data collected is intended for use in the doctoral dissertation of the researcher. A secondary intent is to use the data and findings of the research in conference presentations, journal articles, and in other scholarly works in the fields of Nursing, Educational Administration, and Leadership Studies. Participants will be made aware of the intents of the data collection prior to participating in the study and, when the dissertation is complete, a notice will be sent to each participant informing them of the availability of the study from the University of Saskatchewan Library.

**RISKS, BENEFITS, AND DECEPTION:** There are no known risks from participation in this study. Participants may decline to answer specific questions, and may opt to delete responses from transcripts, on review.

**CONFIDENTIALITY:** Pseudonyms will be used when referring to the participants within the study, and for any groups and organizations with which they are affiliated, in both transcription and reporting of the data. Signed consent forms, participant information and data will all be stored separately. No direct quotations will be used in the report of the study without the consent of the participant. In addition, participants will be provided with an opportunity to review the transcripts of their interviews and to make any additions, deletions, or alterations, without repercussion. However, because the data is collected from a small population of nursing leaders working to enhance diversity within the profession, the researcher may not be able to guarantee anonymity. Participants will be alerted to this fact prior to providing consent. Participants may withdraw from the study at any time, with withdrawal of any data gathered to that point.

**DATA/ TRANSCRIPTION RELEASE:** See Appendix 2 for Transcript Release forms.

**DEBRIEFING AND FEEDBACK:** Participants will have an opportunity to provide feedback on transcripts of the audio taped interviews. Transcripts of interviews will be reviewed prior to the subsequent interviews. At each step of the process participants will have an opportunity to ask questions or make comments. Participants will be provided with contact information for the researcher, the Department of Educational Administration, and the Office of Research Services of the University.

**REQUIRED SIGNATURES:**

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Lois Berry, Doctoral candidate

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Dr Keith Walker, Supervisor

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Dr Sheila Carr-Stewart, Department Head

**REQUIRED CONTACT INFORMATION:**

**RESEARCHER CONTACT INFORMATION**

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### **SUPERVISOR CONTACT INFORMATION**

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## APPENDIX 1

### Request for Assistance from Nurse Leaders & Stage 1 Participants

Date:

Mr. /Ms. /Dr. Doe

Address

Dear Mr. /Ms./Dr. Doe:

Thank you for agreeing to further assist me by contacting potential participant(s) for my study *Making a diversity difference: Stories of leadership creating a more inclusive nursing profession*, which I am completing as part of my doctoral studies in the Department of Educational Administration, College of Education at the University of Saskatchewan.

As per our previous discussion, I am including here an email copy of a Letter of Invitation/ Information about the Study/ Consent Form which you have agreed to forward to \_\_\_\_\_. Please feel free to read the enclosed letter, and to keep a copy for your files.

If you encounter any problems in contacting \_\_\_\_\_, or have any questions or concerns, please contact me via phone (collect), email or mail. My contact information is provided below.

Yours truly,

Lois Berry

Doctoral Candidate

Department of Educational Administration

College of Education

28 Campus Drive

University of Saskatchewan  
Saskatoon, SK, S7N 0X1

Phone: 306-966-6308

Email: [lois.berry@usask.ca](mailto:lois.berry@usask.ca)

**APPENDIX 1 (continued)**  
**Letter of Invitation/ Information about the Study/ Consent form**

Date:

Mr./Ms./Dr. Doe

Address of invitee

Dear Mr./Ms./Dr. Doe:

I am a nurse and a doctoral candidate in the Department of Educational Administration, College of Education at the University of Saskatchewan. I am conducting a study entitled *Making a diversity difference: Stories of leadership creating a more inclusive nursing profession*.

The purpose of this study is to elicit stories of the experiences of leaders in nursing who have successfully promoted inclusion in the profession of underrepresented groups, specifically Aboriginal people, visible minorities and immigrants. It will explore the stories of how these leaders have come to identify the importance of increasing the diverse makeup of the nursing profession, how they conceptualize diversity and inclusion, how they experienced resistance and barriers in attempting to increase inclusion, and how they foster increased participation of diverse groups in the profession. The study is intended to shed light on the experiences of leaders for inclusion in nursing with the intent of increasing our understanding of, and success in creating, a more inclusive nursing profession.

This letter is your invitation to participate in this study. You are being asked to participate because you have been identified to me by one or more recognized Canadian

nurse leaders as a leader in promoting the inclusion of Aboriginal, visible minority or immigrant people in the profession.

This is a qualitative study using an adapted narrative inquiry approach, which will focus on the stories of up to six study participants. Participants will be asked to participate in up to two in- depth semi-structured interviews of a maximum of two hours each. Interviews will be in-person wherever possible, but will be conducted by telephone if logistics do not permit face-to-face interviews. Interviews will be conducted between January 30, 2009 and January 30, 2010. With your written consent, the interviews will be taped and transcribed. You will be asked to review the transcripts and will have an opportunity to add, alter or delete any information as you see fit. You will also be asked to sign a consent form for release of the transcripts following your review of them. The researcher will bear all costs incurred as a result of the interview process.

Your participation is voluntary, and you can answer only those questions with which you are comfortable. There is no guarantee that you will personally benefit from your involvement. You may withdraw from the research project for any reason, at any time, without penalty of any sort.

As a participant in this study you may expect to benefit in the following ways: The opportunity to participate in a qualitative study that will advance our understanding of leadership and inclusion in our profession, and, the chance to reflect on your own experiences with leadership and inclusion in our profession. The study will pose no risks to you as a participant.

Every effort will be made to ensure anonymity of study participants. Pseudonyms will be used to identify participants in the study report, and identifying information (place of employment, location etc.) will be described in generic terms. The data will be stored in accordance with research ethics policies of the University of Saskatchewan, and will not allow for identification of any participants. This study was approved by the

University of Saskatchewan Behavioral Ethics Board on March 20, 2009. While every effort will be made to assure anonymity of participants, it is recognized that the community of nursing leaders focusing on a diverse nursing profession is small, and the unique perspectives and experiences of such leaders may be recognizable to others with an interest in the field. Because of this, anonymity cannot be absolutely guaranteed.

You will find attached to this email, a consent form for participation in this study. Should you be willing to participate in this study, please complete the consent to participate and return it to me at [lois.berry@usask.ca](mailto:lois.berry@usask.ca), or by mail to my address provided below. If returning the consent by mail, please sign and date. If responding via email, please note that returning the consent form via email will constitute properly attained consent. Upon receipt of your response I will contact you to set up a mutually appropriate interview schedule.

I look forward to your response to this request to participate. If you have any questions about this study, please contact me at 306-966-6308, or by email at [lois.berry@usask.ca](mailto:lois.berry@usask.ca). You may also contact my dissertation supervisor, Dr. Keith Walker, at 306-966-7623, or via email at [keith.walker@usask.ca](mailto:keith.walker@usask.ca). If there are any concerns regarding ethical issues, you may contact the Ethics Officer at the University of Saskatchewan at 306-966-2084.

Sincerely,

Lois Berry  
Doctoral Candidate  
Department of Educational Administration  
College of Education  
28 Campus Drive  
University of Saskatchewan

Saskatoon, SK, S7N 0X1

**APPENDIX 1 (continued)****Consent to Participate in the Study:** *Making a diversity difference: Stories of leadership creating a more inclusive nursing profession*

I have read and understood the description provided above. I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. A copy of this consent form has been provided for my records.

I consent to participate in the study described above, understanding that I may withdraw consent at any time. I consent to allow the interviews, either in person or via telephone, to be taped and transcribed. I understand that I will have an opportunity to review the transcripts and add, alter, or delete any information.

I understand that the research project results and associated materials will be safeguarded and securely stored by a faculty member of the University of Saskatchewan, Dr. Keith Walker, for a minimum of five years, and that, when they are no longer required, they will be appropriately destroyed.

I understand that further information regarding this study can be obtained by contacting the researcher at 306-966-6308, or by email at [lois.berry@usask.ca](mailto:lois.berry@usask.ca). I understand that I may also contact the dissertation supervisor, Dr Keith Walker, at 306-966-7623, or via email at [keith.walker@usask.ca](mailto:keith.walker@usask.ca). I further understand that I may contact the Ethics Officer at the University of Saskatchewan at 306-966-2084 if there are any concerns regarding ethical issues.

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Signature of participant

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Date

---

Signature of researcher

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Date

\*\* Returning this form by email, without handwritten signature, constitutes provision of consent.



## APPENDIX 2

### Letter of Consent for Release of Transcripts/Data

I appreciate your participation in the research study *Making a diversity difference: Stories of leadership creating a more inclusive nursing profession*.

I am returning the transcripts of the audio taped interviews for your perusal and the release of confidential information. I will adhere to the following guidelines, which are designed to protect your confidentiality and interests in the study.

1. Please read and recheck the transcripts for accuracy of information. You may edit or clarify the transcripts using additional comments. Feel free to write directly on the transcripts. You may also delete any information that you may not want to be quoted in the study.
2. The data from this study will be used in the doctoral dissertation, scholarly journal articles, or similar publications and presentations. Except to the researcher in the study, your participation has remained confidential. You will not be identified as a participant nor will your name or work circumstances be used in the final document, scholarly articles, or presentations.
3. In accordance with the University of Saskatchewan Guidelines on Behavioural Research Ethics, data collected during the study will be secured and remain so for a minimum of five years as mandated by the University. After this period of time all data will be destroyed.
4. Participation in this study is voluntary and you may withdraw at any time without repercussions. If this happens, the data will not be used.

I \_\_\_\_\_ understand the guidelines above and

(Please sign your name)

agree to release the data/transcripts as I have indicated.

Name of participant: (printed) \_\_\_\_\_

Date: \_\_\_\_\_

Researcher's Signature: \_\_\_\_\_

**\*\* Returning this form by email, without handwritten signature, constitutes provision of consent.**

## **APPENDIX 3**

### **Interview Guide**

#### **Interview 1: Diversity, inclusion, and the nursing profession**

Initial interaction will be directed at establishing rapport, reviewing the purpose of the study, and the focus of each interview. Reminders will be given regarding confidentiality and the rights of the participant to alter, add, or delete any comments from the transcripts and to withdraw at any time.

1. Please share with me some stories about your background and your nursing career. Where did you grow up? Where did you study nursing?
2. Is there a story around how you came to choose nursing as a career? And what about how you came to be where you are today? Do you believe that there are overarching values or purposes expressed in these stories that contribute to where you are today?
3. My research is about leadership in relation to diversity and inclusion in nursing. From your experience, could you comment on how you see diversity and inclusion? What do the terms diversity and inclusion mean to you personally? Are there stories you could share with me about these views?
4. You are known as a nurse that is committed to promoting diversity and inclusion in nursing. How do you think others have come to see you in this way?

5. How did you come to be interested in diversity and inclusion? Are there any life experiences and stories that have inspired your commitment to diversity and inclusion?
6. Can you share some of your experiences with diversity and inclusion? In general? In nursing particularly?
7. Are there some basic beliefs and values which sustain your interest in diversity and inclusion? How did you come to these beliefs and values?
8. Are there any personal or professional relationships that have particularly sparked your interest in diversity and inclusion? Can you share the stories of these relationships?
9. What are your experiences with respect to the commitment of nursing as a profession to diversity and inclusion within the profession itself? Could you tell me stories of your experiences -- at the level of individuals, institutions and the profession itself, as applicable? (Probe with respect to barriers and supports experienced)
10. If you were addressing a group of nursing leaders, what would you say to them regarding diversity and inclusion in the profession?

## **Interview 2: Leadership**

Review the purpose of this interview (focus on leadership) and confidentiality.

Do you have any questions or reflections triggered by our first discussion?

1. From our previous discussion, it seems that the following themes emerged?  
(List) Do you agree? Do you have any additional comments on these themes?
2. How do you see leadership? What does it mean to you? Can you share with me a story that illustrates this?
3. Can you share some stories of the leaders that have influenced your life? What made them effective, or ineffective?
4. What is the story behind how you came to be a leader in nursing? In general? In relationship to diversity and inclusion?
5. Are there some basic beliefs and values that sustain you as a leader? What are they?
6. Are there any life experiences and stories that have particularly sparked your interest in leadership?
7. How do you see your role in providing leadership? In general? In relation to diversity and inclusion? In relation to diversity and inclusion in nursing?
8. Tell me about some successes, and some less than successful leadership stories, in promoting diversity and inclusion in nursing. What made the difference in these experiences?
9. If you were addressing a group of nursing leaders, what would you say to them regarding leadership in the profession?
10. If you were addressing a group of nursing leaders, what would you say to them regarding leadership for diversity and inclusion within the profession?

11. (This question will be asked of the Stage 1 participants.) I am interested in interviewing more participants for this study. I am interested in interviewing formal and informal nurse leaders who are committed to increasing diversity in nursing from a social justice perspective. I am particularly looking for participants who have provided leadership for diversity in the area of (*Note: The researcher will select the appropriate area of nursing—nursing education, nursing practice, nursing regulatory body—the appropriate group—immigrants, visible minorities, and Aboriginal people--and the appropriate geographic area, to provide for variety in the sample of participants.*) Can you suggest anyone who would meet these criteria? What is there about this person and her or his experience that makes them appropriate for the study from your point of view? Would you be willing to contact them by email and provide them with my letter of invitation to participate in the study?

## APPENDIX C

### Ethics Approval Certificate



**UNIVERSITY OF  
SASKATCHEWAN**

Behavioural Research Ethics Board (Beh-REB)

#### *Certificate of Approval*

PRINCIPAL INVESTIGATOR  
Keith D. Walker

DEPARTMENT  
Educational Administration

BEH#  
09-16

INSTITUTION(S) WHERE RESEARCH WILL BE CONDUCTED  
University of Saskatchewan  
Saskatoon SK

STUDENT RESEARCHERS  
Lois Berry

SPONSOR  
UNFUNDED

TITLE  
Making a Diversity Difference: Stories of Leadership Creating a More Inclusive Nursing Profession

ORIGINAL REVIEW DATE  
20-Jan-2009

APPROVAL ON  
20-Mar-2009

APPROVAL OF:  
Ethics Application  
Consent Protocol

EXPIRY DATE  
19-Mar-2010

Full Board Meeting ☐

Date of Full Board Meeting:

Delegated Review ☒

#### **CERTIFICATION**

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

#### **ONGOING REVIEW REQUIREMENTS**

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: [http://www.usask.ca/research/ethics\\_review/](http://www.usask.ca/research/ethics_review/)

**John Rigby, Chair**

University of Saskatchewan  
Behavioural Research Ethics Board

Please send all correspondence to:

Research Ethics Office  
University of Saskatchewan  
Box 5000 RPO University 1602-110 Gymnasium Place  
Saskatoon SK S7N 4J8



UNIVERSITY OF  
SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB)

## Certificate of Re-Approval

PRINCIPAL INVESTIGATOR Keith D. Walker	DEPARTMENT Educational Administration	Beh # 09-16
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INSTITUTION (S) WHERE RESEARCH WILL BE CARRIED OUT

University of Saskatchewan  
Saskatoon SK

STUDENT RESEARCHER(S)

Lois Berry

SPONSORING AGENCIES

UNFUNDED

TITLE:

Making a Diversity Difference: Stories of Leadership Creating a More Inclusive Nursing Profession

RE-APPROVED ON

11-Feb-2010

EXPIRY DATE

10-Feb-2011

Full Board Meeting ☐

Delegated Review ☒

### CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

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John Rigby, Chair  
University of Saskatchewan  
Behavioural Research Ethics Board

Please send all correspondence to

Research Ethics Office  
University of Saskatchewan  
Box 5000 RPO University  
Room 1607 - 110 Gymnasium Place  
Saskatoon, SK S7N 4J8



## APPENDIX D

### Letter of Attestation

#### Letter of Attestation

This letter of attestation is in relation to the inquiry audit of the Ph.D. dissertation written by Lois Berry entitled "Making a Diversity Difference: Stories of Leadership Creating a More Inclusive Nursing Profession."

The purpose of this study is to elicit stories of nursing leadership that successfully promoted diversity and enhanced inclusiveness within the profession. The research problem was stated as follows: "What were the experiences and stories of nurse leaders who successfully provided leadership to increase diversity and inclusion within the profession?"

The research was built on a conceptual framework consisting of three major concepts: diversity, critical leadership and professional closure.

#### **The Audit Procedure --Verification and Accuracy of Transcripts and Disk Recordings.**

##### **1. Consent and Data/Transcript release forms**

All of the 'Consent forms' and 'Data/Transcript Release Forms' for the 5 participants in this research study are reviewed for signatures and completion. The forms:

- a) list the participants of the study provided for the audit and
- b) are signed by the participants and the researcher.

##### **2. Selection of Samples for Verification and Accuracy of Disk Recordings to Transcripts:**

###### **a) Procedure and Observations for disk to transcripts tests:**

There are 11 interview files provided on a stick. Three files are randomly chosen. The first page of each and then 3 times during fast-forwarding, the tapes were paused to compare audio statements to the transcripts to note any discrepancies.

###### **b) Accuracy of Quotations in Relation to Data Sources**

All comparisons between recordings and transcripts were positive. The words spoken on disk were the words that appeared in transcripts.

##### **3. Accuracy of Dissertation Chapter Four References to Transcripts:**

###### **a) Procedure and Observations for Chapter 4 references.**

I observed 248 quoted references to the working papers in chapter 4. I chose a random sample of 15 of those references and compared them to the supporting working documents.

###### **b) Accuracy of References in Dissertation to Disk Recording Transcripts.**

All references investigated in Chapter Four were found and verified as accurate.

#### 4. Inspection of Ethics Proposal and Certificate.

I have reviewed the candidate's application for approval of Research Protocol and the ethics statement provided. The procedures used by researcher and the protocols followed in the research are consistent with this approval. An analysis of the data reduction and interpretation of data was not considered by this audit. It remains for the researcher to turn the materials above, over to the University for secure storage for a five-year period.

#### 5. Summary

Despite minor omissions the transcripts and data files are accurate transcriptions of the recorded interviews. The transcription of quotations in the dissertation represent a faithful record of the stick-held interview transcripts.

As a result of the audit, I as auditor, testify that the transcripts/data sheets which I have examined in relation to the Lois Berry dissertation are true and accurate.

Eric Campbell

Eric Campbell, B. Comm., M.B.A. (Queens) (retired member Institute of Internal Auditors and Association of College and University Auditors)

2010-06-23